IBEW LOCAL NO. 9 AND LINE CLEARANCE CONTRACTORS HEALTH & WELFARE FUND

Summary Plan Description/Plan Document

Benefits and Eligibility Rules

Effective July 1, 2019

Notice

This booklet contains a description in English of your rights and benefits under the IBEW Local No. 9 and Line Clearance Contractors Health & Welfare Fund (the “Plan”).

If you have difficulty understanding any part of this booklet or difficulty understanding any information that you receive from the IBEW Local No. 9 and Line Clearance Contractors Health & Welfare Fund, you may receive assistance in Spanish by contacting the Fund Office between the hours of 7:30 a.m. and 5:30 p.m., Monday through Friday, Eastern Time. The Fund Office is located at 6525 Centurion Drive, Lansing, Michigan 48917 and can be reached by telephone at (517) 321-7502 and toll-free at (877) 423¬9155.

Please pay attention to every letter and notice you receive from the Health and Welfare Fund about your health care coverage and respond immediately to any request for information and/or payment. A timely response and payment, when required, is essential to continue your health care coverage without interruption.

Notice of Grandfathered Status:

The Trustees believe this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”) which permits us to preserve certain basic health coverage already in effect before the law was enacted. Being a grandfathered health plan means that your Plan does not have to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 6525 Centurion Drive, Lansing, Michigan 48917 or by calling toll-free at 1-877-423-1955. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or http://www.dol.gov/ebsa/healthreform. This website has a chart summarizing what protections do and do not apply to grandfathered health plans.

Aviso

Este folleto contiene un resumen en inqles de sus derechos y beneficios bajo el Local No. 9, IBEW y Line Clearance Contractors Health and Welfare Fund.

Si usted tuviera dificultad para entender cualquier parte de este folleto, o dificultad para entender cualquier informacion que usted reciba de Local No.9, I.B.E.W. & Line Clearance Contractors Health and Welfare Fund, usted puede recibir ayuda en español contactando a la Oficina del Fondo entre las horas de 7:30 a.m. y 5:30 p.m. Eastern Standard Time, de lunes a viernes. La Oficina del Fondo esta ubicada en 6525 Centurion Drive, Lansing, Michigan 48917, y puede contactarse por teléfono en el (517) 321 -7502 Y gratis en el (877) 423¬9155.

Por favor preste atendon a toda carta y aviso que reciba del Fondo de Salud y Bienestar sobre su cobertura de atendon medica y responda inmediatamente a cualquier pedido de informacion y/o de pago. Una respuesta y un pago oportunos cuando se requiera, es esencial para continuar su cobertura de atendon medica sin interrupcion,

Por favor llame a La Oficina del Fondo si usted tuviera dificultad para entender cualquier informacion que usted reciba de ellos.

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ABOUT YOUR PLAN

Your Employer and the Union have created a Welfare Fund for you and your fellow workers. The Fund provides a specific, dependable plan of benefits. This Plan is being improved constantly in an effort to provide you with the best benefits possible consistent with sound financial management of the Plan. The IBEW Local No. 9 and Line Clearance Contractors Health & Welfare Fund is maintained as a result of a collective bargaining agreement, sometimes referred to as a labor contract, between your Employer and the Union.

Your Welfare Fund receives its money from Employer contributions, on dates and in amounts called for by the labor contract negotiated with the Employer by your Union. Money is not withheld from your paycheck in order to support the Fund.

Decisions on Plan operations and benefits are made by a Board of Trustees, on which labor and management are equally represented.

Working together, the Board of Trustees establishes the Eligibility Rules, strives to maintain the schedule of benefits, supervises the investment of the Fund's money and sees that the Fund is in compliance with all applicable federal laws and regulations.

In carrying out these responsibilities, the Trustees are assisted by a team of professionals including:

The **Administrative Manager** who handles the day-to-day business activities of the Fund such as collecting Employer contributions, keeping records of money received, crediting each Employee’s account with the correct number of hours worked, paying claims and answering inquiries from Employees about their eligibility and benefits.

The **Fund Attorney** advises the Trustees about what must be done to assure that all operations of the Fund comply with federal and state laws.

The **Fund Investment Consultant** advises the Trustees about how to invest any reserves not needed to pay current Fund expenses.

The largest part of contributions the Fund receives is returned directly to Employees in the form of benefits. Some of the contributions received are set aside for reserves. The Fund's reserves can be drawn on at times when the claims expenses exceed the income from Employer contributions.

As required by law, the Fund has an independent auditor examine the financial records each year and certifies them as to their accuracy, completeness and fairness. In addition, the Trustees are required to submit annual financial statements and other reports to the U.S., Department of Labor and the Internal Revenue Service. These reports are available for inspection at the Fund Office during normal business hours.

This, then is a description of how your Fund was established, what its purpose is and how it operates. This Summary Plan Description and Plan Document replaces and supersedes all previous Summary Plan Descriptions and Plan Documents. This Summary Plan Description and Plan Document describes the benefits in effect as of January 1, 2019.

Contact Information

If You Have a Question About…	Contact…
• Eligibility • Claims • COBRA • Short-Term Disability • General Questions	IBEW Local No. 9 and Line Clearance Contractors Health & Welfare Fund c/o TIC International Corporation • Phone: (877) 423-9155 • Fax: (517) 321-7508 • Web: www.ibew9lctt.org
Medical Benefits	BlueCross BlueShield of Illinois (BCBSIL) • Phone: (800) 862-3386 • Care Management Phone: (800) 635-1928 • Web: www.bcbsil.com
• Prescription Drug Benefits • Prescription Drug Pre-Authorization	Prime Therapeutics • Phone: (855) 457-0007 • Web: https://www.primetherapeutics.com/
• Membership Assistance Program (MAP) • Mental Health and Substance Abuse Treatment	Employee Resource Systems (ERS) • (800) 292-2780 • www.ers-eap.com
Dental Benefits	Delta Dental of Illinois • Phone: (800) 323-1743 • Web: www.deltadentalil.com
Vision Benefits	Vision Service Plan (VSP) • Phone: (800) 877-7195; Monday - Friday 5 a.m. to 8 p.m., Pacific Time; Saturday 7 a.m. to 8 p.m., Pacific Time; Sunday 7 a.m. to 7 p.m., Pacific Time • Web: www.vsp.com

YOUR RESPONSIBILITIES AS AN EMPLOYEE

There are certain responsibilities, which you, as an Employee, must assume. Failure to carry out these responsibilities could affect your eligibility for benefits payable on your behalf.

1. Take time to read this Summary Plan Description.
2. Complete and file a Health Care Enrollment Form.
3. Notify the Fund Office promptly, in writing, if you have:
    a. A change of address; or
    b. A change in marital status; or
    c. A change in beneficiary; or
    d. A change in dependents.
4. Fully complete a claim form each time you submit charges for any medical expense.
5. Make self-payments, if necessary, on time and in the correct amount. A more detailed explanation of your responsibilities can be found in the appropriate section of the Plan Description. Please refer to the Table of Contents for page numbers.

If You Move, Notify The Fund Office Immediately!

Most information about the Plan is sent to you by mail. For you to receive this information, we must have a correct address on file at the Fund Office at all times.

If you move, it's up to you to let us know your new address. Failure to do so may jeopardize your eligibility or benefits because we have no way to contact you about any changes in the Eligibility Rules or improvements in benefits.

So don't lose out! Remember: the responsibility for letting the Fund Office know your new address is yours.

The Fund Office will mail you forms upon request, which you may use to notify the Fund Office about an address or designated beneficiary change. If you have access to the internet, the address change form is available on the Fund's website at www.ibew9lctt.org. You may download the form to print it out and send it to the Fund Administrator.

Please send the completed forms to:

IBEW Local No. 9 and Line Clearance Contractors Health & Welfare Fund
c/o TIC International Corporation
6525 Centurion Drive
Lansing, Michigan 48917-9275
Phone: (877) 423-9155
Fax: (517) 321-7508
Web: http://www.ibew9lctt.org/

HOW TO COLLECT BENEFITS

Once you become eligible, this Fund has the responsibility for seeing that you receive all the benefits to which you are entitled. To receive these benefits, you must also assume some responsibility. Benefits are not paid automatically; you must file a claim to collect benefits.

Different types of claims may require you to complete different types of claim forms. Sometimes your medical provider will submit claims directly to the Fund for payment. You should ask your provider if they intend to submit a claim directly. If you need to submit the claim, you may obtain the proper form from Blue Cross Blue Shield of Illinois (BCBSIL). If the claim form asks you to submit it to a different office for processing, you should follow the directions on the form.

If you are applying for Short-Term Disability (also known as Weekly Loss of Time) benefits, be sure that you and your Physician complete the appropriate areas on the claim form. If loss of time continues for an extended period, you will be asked to complete additional claim forms. Your Physician must also certify, on his portion of the claim form, that you are still disabled.

To receive benefits provided by the Fund, **all** Eligible Persons must comply with every applicable claim rule and the Trustees reserve the right to deny benefits to any Eligible Person who is, in their opinion, attempting to subvert the purpose of the Fund or who does not, in their opinion, present a bona fide claim.

The Fund Office can provide you with the forms needed for filing a claim or a proof of loss. Additionally, the claim forms can be provided by the different service providers who pay the various types of claims. For example, BCBSIL pays the medical and prescription drug claims. BCBSIL can provide you with these forms. Delta Dental of Illinois pays the dental claims. Delta Dental of Illinois can provide you with the forms for these types of claims. Vision Service Plans (VSP) pays the vision claims. VSP can provide you with vision claim forms. The Fund Office pays Short-Term Disability. The Fund Office can provide you with Short-Term Disability forms. Finally, Sun Life pays the life insurance and accidental death & dismemberment claims and Sun Life provides these claim forms. The various claim forms will instruct you on how to submit your claims for processing.

Although BCBSIL, Delta Dental of Illinois, VSP and Sun Life ("the Claims Paying Agents") all pay claims and although their names may appear on the claim forms, the benefits are controlled by the Board of Trustees and are paid out of the Trust Fund. The life insurance and accidental death & dismemberment benefits paid by Sun Life are insured. The Trustees purchased group insurance policies for these two types of benefits and the insurance policies will control payment of these claims.

General Payment Provisions

Upon submission of adequate proof and subject to any written direction of the Employee, all or a portion of any benefits provided by the Plan may at the Trustees' option, be paid directly to the Hospital or person rendering the services provided.

Written proof of Short-Term Disability benefits due to disability or Hospital confinement must be furnished to the appropriate Claims Paying Agent within 90 days after the termination of the period for which the claim is being made. Written proof of any other loss on which the claim may be based must be furnished to the Claims Paying Agent not later than 90 days after the date of

the loss. Failure to furnish notice or proof of claim within the time provided in the Plan will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time and proof is furnished as soon as reasonably possible. **However, in no event may any claim be submitted later than one year from the date of loss.** The date of loss is the date the service was provided. In the case of Hospital confinement, the date of loss is the first date of confinement. In the case of a short-term disability (a disability lasting no more than 26 weeks), the date of loss is the first date of the disability. In the event of a course of treatment, the date of loss is the first date of treatment within the course of treatment.

Benefits payable under the Plan for any loss other than Short-Term Disability will be paid as they accrue immediately upon receipt of due written proof of loss. Subject to due written proof of loss, all accrued benefits for Short-Term Disability will be paid at the times set forth in the applicable benefit provision and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Life Insurance benefits will be payable in accordance with the beneficiary designation form on file at the Fund Office and in accordance with the provisions with respect to such payments which are prescribed in the Sun Life Insurance Booklet. The Sun Life Insurance Booklet, which is available upon request from the Fund Office, provides for a method of distribution if you do not complete a beneficiary designation card and it is as follows:

Payment will be made as follows if you name a beneficiary(ies):

1. If more than one beneficiary is named, each will be paid an equal share.

2. If any named beneficiary dies before you, his share will be divided equally among the named surviving beneficiaries.

If no beneficiary is named or if no named beneficiary survives you, the Fund may, at its option, pay:

1. The executors or administrators of your estate; or

2. Your surviving relatives in the following order:

    a. All to your surviving spouse; or

    b. If your spouse does not survive you, in equal shares to your surviving children; or

    c. If no child survives you, in equal shares to your surviving parents.

Therefore, if you wish to have control over the distribution of this benefit, you should complete a beneficiary designation card and keep it current and on file at the Fund Office.

Benefits under this Plan will be paid only if the Board of Trustees decides in its discretion that the applicant is entitled to them. This provision applies to all benefits payable under the Plan.

ELIGIBILITY RULES

All Employees working in Covered Employment shall be eligible to receive benefits after meeting the following eligibility requirements. Covered Employment means work performed for a Contributing Employer or Employers within the jurisdiction contained in the Collective Bargaining Agreement and for which the Employer is obligated to make, and has made, contributions to the Fund.

Initial Eligibility

An Employee (hereafter "you") initially becomes eligible after he has worked at least 500 hours in Covered Employment. Specifically, you become eligible on the first day of the second month after the month in which you have completed the 500 hours of work. The Contributing Employer reports the hours worked and pays the contributions to the Fund on your behalf. The 500 hours must be worked in Covered Employment and at least within a period of six consecutive calendar months. If you work 500 or more hours in three consecutive calendar months then, you will become eligible on the first day of the fifth month. You will remain eligible for one month only.

For example, if your Employer contributed for 500 or more hours for you during the work months of January, February, March, April, May and June; your eligibility will begin effective August 1. You will remain eligible for August only.

However, if your Employer contributed for 500 or more hours for you during the work months of January, February and March, your eligibility will begin effective May 1. You will be eligible May only.

Initial eligibility must again be satisfied if an Employee has been ineligible for more than 12 consecutive months.

Continuing Eligibility

You will remain eligible so long as your Employer continues to report at least 100 hours worked in Covered Employment per month. In the event that your Employer fails to report at least 100 hours worked in Covered Employment in a certain month, you can utilize any hours in excess of 100 that were reported in the prior month. In addition, the Trustees may permit you to pay up to 80 hours maximum within a calendar year at the self-pay rate determined by the Trustees. For further details about the self-payment procedures please refer to the section entitled self-payment of Contributions which appears later in these Eligibility Rules. After you have exhausted the maximum self-payment hours, you may be eligible to continue your eligibility pursuant to the COBRA rules as reflected in this booklet.

Your eligibility ends on the last day of the second calendar month following the last work month for which your Employer made contributions on your behalf for at least 100 hours worked in Covered Employment. For example, if your Employer last contributed 100 or more hours for your work in Covered Employment during the month of May, your eligibility will last be in effect on July 31.

Continuation of Coverage During a Work-Related Period of Disability

If you become disabled while you are eligible under this Plan and you cannot work in Covered Employment and your disability arose out of or in the course of, your employment, your eligibility may be continued if your Employer voluntarily makes contributions on your behalf or if your Employer is obligated to make contributions on your behalf pursuant to a Workers Compensation or Occupational Disease Law.

Continuation of Coverage During a Non-Work-Related Period of Disability

If you become disabled while you are eligible under this Plan and you cannot work in Covered Employment and your disability did not arise out of or in the course of, your employment, your eligibility may be continued by the Plan providing you with the required credits in the event that your Employer does not voluntarily make contributions on your behalf. The Fund may credit up to 100 hours per month for up to 26 weeks for the duration of your disability. You will be required to file an application for short-term disability benefits to become eligible for these credits. You will be required to provide proof of your disability by providing appropriate documentation to the Fund Office. In the event you become disabled, you should promptly notify the Fund Office.

Continuation of Coverage During a Leave of Absence

If you take an unpaid Leave of Absence while you are eligible under this Plan and you do not work in Covered Employment, your eligibility may be continued if your Employer voluntarily makes contributions on your behalf or, if your Employer is obligated to make contributions on your behalf, pursuant to any legal obligation.

Continuation of Coverage During Work Under a Different Collective Bargaining Agreement (Jurisdiction with Reciprocity)

When you leave the jurisdiction of IBEW Local No. 9, to work at the trade in Covered Employment under another Collective Bargaining Agreement in the jurisdiction of another IBEW Local Union, the Employee's eligibility under this Plan is governed by the requirements of this section of the Eligibility Rules.

Termination of Coverage During Work Under a Different Collective Bargaining Agreement (Jurisdiction without Reciprocity)

When you leave the jurisdiction of IBEW Local No. 9 to work at the trade in Covered Employment under the jurisdiction of an IBEW Local Union that does not have a Reciprocal Agreement either through the International Brotherhood of Electrical Workers or directly with IBEW Local No. 9, your eligibility (and that of any Eligible Dependents) terminates on the earlier of:

1. The last day of the second calendar month following the last work month for which your Employer made contributions of at least one hundred (100) hours worked in Covered Employment or

2. The first day of the month in which you are covered or become eligible for coverage, under any other group health care plan or program.

Return to Covered Employment (Reinstatement of Eligibility)

When you return to Covered Employment within IBEW Local No. 9's jurisdiction, your eligibility may be reinstated in this Plan on the first day of the second month following the month in which you performed Covered Employment for an Employer required to contribute to this Fund. In this event, you may not be subject to the Initial Eligibility requirements and may only be subject to the Continuing Eligibility requirements. Please contact the Fund Administrator after you have returned to Covered Employment to determine if you can meet the Continuing Eligibility requirements to reinstate your eligibility.

Eligibility on and after the first day of the month following the reinstatement of your eligibility is governed by the normal "Continuing Eligibility" section.

If you fail to meet these requirements or, if you do meet the requirements but do not reestablish eligibility within 12 months after your eligibility terminated, then you must meet the requirements under "Initial Eligibility" in these Rules to reinstate your eligibility.

Method of Calculating Contributions from a Jurisdiction with Reciprocity

The Trustees of the IBEW Local No. 9 and Line Clearance Contractors Health & Welfare Fund have entered into Reciprocal Agreements with the Trustees of similar IBEW Welfare Funds operating in the various jurisdictions of other IBEW Local Unions. Under these Reciprocal Agreements, contributions for hours worked at Covered Employment in the jurisdiction of another IBEW Local Union may be transferred to this Fund for use in continuing your eligibility.

The amounts to be transferred and the way in which those transfers are credited to your records is governed by the individual Reciprocity Agreement and by the administrative procedures adopted by this Fund's Trustees. You should inquire about the availability of Reciprocal transfers at the Fund Office before you leave the jurisdiction of IBEW Local No. 9.

Electronic Reciprocal Transfer System ERTS

The International Brotherhood of Electrical Workers ("the International Union") has implemented an Electronic Reciprocity Transfer System (ERTS). The system is designed to permit an IBEW member to register electronically one time and to designate one local Union as his "home local" for reciprocity purposes. Participation by the Fund in ERTS is mandatory.

To the extent that ERTS is operational, the rules established by the ERTS Reciprocal Administrator will control any contrary provisions of this document. If you plan to travel outside of IBEW Local No. 9's jurisdiction and to work in Covered Employment, you should contact the Fund Office and the appropriate IBEW Local Unions first to determine if the ERTS will apply to your situation.

Continuation of Eligibility for Dependents in the Event of an Employee's Death

If you die while you are eligible under these Rules, your Eligible Dependents may continue to be eligible according to the following requirements. Eligibility for surviving dependents will continue automatically, without self-contribution, until the date on which your eligibility would have terminated had your death not occurred.

For example, if an Employee, John, dies in March after having worked at least 100 hours in Covered Employment then, John's surviving dependents will continue coverage until the end of May.

Surviving dependents will have this continued eligibility so long as they continue to meet the definition of Dependent under the terms of the Plan.

Continuing Eligibility under the Uniformed Services Employment and Reemployment Rights Act

If you enter into military service as defined by the provisions of the Uniformed Services Employment and Reemployment Rights Act (USERRA), you may be able to continue coverage for 24 months under this Plan. If your military service is less than 31 days, your Plan coverage continues at no cost to you. If your military service is more than 31 days and if you qualify, USERRA provides that you may elect to continue coverage at a cost of not more than 102% of the actual cost of coverage in effect at the time of such eligibility. In this case, the Plan permits you to continue coverage at the self-pay rate as reflected in the section below entitled “Self-Payment of Contributions.”

In the event that you are reemployed by a Contributing Employer and provided that USERRA applies, you will immediately receive eligibility upon your return to Covered Employment. The Board of Trustees shall determine the liability for any Employer contributions due to the Plan in conformance with the provisions of USERRA. Your Dependent's eligibility will cease the day the Dependent is inducted into the Armed Forces of the United States.

Reinstatement of Eligibility following a period of ineligibility

Employees

If you once established eligibility under this Plan and lose that eligibility at a later date, you may be reinstated under continuation of eligibility in these Rules if you have been ineligible no more than 12 consecutive months. If you remain ineligible for more than twelve 12 consecutive months, then you must meet the requirements under "Initial Eligibility" in these Rules to reinstate eligibility.

If you are not actively working due to disability on the day you would otherwise reinstate your eligibility, you will not become eligible for benefits until you return to active employment as described under Initial Eligibility.

Dependents

The Plan will cover your children until the last day of the month in which they turn age 26, regardless of whether they are students, live with you, are married or unmarried, disabled or are receiving Continuation Coverage under COBRA. This applies to your natural children and those you have legally adopted or were placed with you for adoption, stepchildren and foster children. The Plan will continue to cover children under a Qualified Medical Child Support Order (QMCSO).

There is no age limit on coverage for an unmarried disabled child who sustains a disability before the day the child reaches age 26, as long as the child is chiefly dependent upon you for financial support, the Fund receives proof of the child’s incapacity within 60 days of the date

eligibility would otherwise end and the child meets the other requirements for such dependents that are outlined in the SPD.

If your adult children are eligible to enroll in another health plan sponsored by either their Employer or their spouse's Employer, they are not eligible for coverage under this Plan.

A Dependent child who loses eligibility for reasons other than age may have eligibility reinstated on the first day of the month after the month in which the child again meets all requirements of the Dependent definition, provided the child has not remained ineligible for more than 18 consecutive months. You are responsible for notifying the Fund Office if your Dependent child again meets all requirements for eligibility. If a Dependent child remains ineligible more than 18 consecutive months, eligibility as a Dependent cannot be reinstated.

Self-Payment of Contributions

The Trustees have established self-pay rates, which may be partially subsidized by the Fund. These rates are modified, from time-to-time, by the Trustees. Please contact the Fund Office for the current rates.

The rate may vary depending on your coverage and your age and if you have optional coverage available. Please contact the Fund Office for the current list of coverage availability.

Self-Payments must be received at the Fund Office within 10 days of the date the self-payment "Notice" is received by you. All "Notices" are sent by mail to the last known address on file at the Fund Office so it is important that any address changes be reported immediately. In any event, self-payments must be received within 30 days of the date the self-payment Notice is sent to your last known address.

Self-Payments are required on a monthly basis in accordance with the eligibility requirements as defined by these Rules. A change in coverage circumstances (such as eligibility for Medicare) will result in the re-determination of the covered person's benefits class effective as of the first day of the calendar month coincident with or next following, the date that the change in circumstances occurred.

Please contact the Fund Office at (877) 423-9155 if you are unsure of your coverage under the self-payment rules.

Change of Eligibility Rules

The Trustees, in their discretion, are empowered to change or to amend these Eligibility Rules at any time.

Extension of Benefits for Retirees

You may be eligible to continue coverage under the Plan for 24 months after your retirement. In order to be eligible, you must meet the following criteria:

- Retire at age 55 or later,
- Have a minimum of 10 years of service,

- Be an active member of the IBEW Local No. 9 and Line Clearance Contractors Union in good standing at the time of retirement,
- You must have worked for an Employer participating in the IBEW Local No. 9 and Line Clearance Contractors Health and Welfare Benefit Fund for at least 50% of the 10-year period prior to retirement,
- Retiree coverage must begin immediately following the end of active coverage, and
- If you retire at or after age 65, or if you reach age 65 while receiving the 24 month extension of benefits, you must be enrolled in both Medicare Parts A and B.
    - Medicare will pay primary unless the Plan is otherwise required to pay primary under the MSP laws.

If you elect to use this extension of benefits, you will still be able to elect COBRA coverage when the extension ends.

If you retire and use your 24 months of retiree coverage, then go back to active employment, you will **NOT** be eligible for another 24 months of retiree coverage.

GENERAL ELIGIBILITY PROVISIONS

The Eligibility Rules are the requirements, which must be met in order for you and your dependents to become and to remain eligible for benefits from this Plan. In the event the requirements are not satisfied, eligibility is lost and benefits are not payable. The Trustees reserve the right to deny eligibility and benefits to any claimant who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan or coverage.

Remember: Changes in employment may have an effect on Employer contributions paid on your behalf. For example, Employer contributions stop if:

1. You change job classifications from covered to non-Covered Employment, even if that employment is with the same Employer; or

2. You change employment from a participating to a non-participating Employer.

You and your dependents may obtain, upon written request to the Union Office, information as to the address of a particular Employer and whether that Employer is required to pay contributions to the Plan.

Effective Dates of Coverage

Employee

Your effective date of coverage as an Employee will normally be the date you satisfy the requirements of the Eligibility Rules. Your coverage is not delayed if you are disabled or confined in a Hospital on that date. However, if you are totally disabled or confined in a Hospital on the date your coverage would otherwise become effective, coverage for the charges related to the disability or confinement may not be eligible for benefits from this Plan. For example, if other coverage applies then, the Coordination of Benefits provision applies.

Dependents

Your effective date of coverage, as a Dependent, will normally be the date the Employee, of whom you are a Dependent, becomes eligible or the date you satisfy the definition of Dependent, whichever is later. Your coverage is not delayed if you or the Employee is disabled or confined in a Hospital on that date. However, if a Dependent is totally disabled or confined in a Hospital on the date his or her coverage would otherwise become effective, coverage for the charges related to the disability or confinement may not be eligible for benefits from this Plan. For example, if other coverage applies, then the Coordination of Benefits provision applies.

For both employees and dependents, if your effective date of coverage occurs during an inpatient hospitalization, coverage will begin on your effective date. Expenses incurred for that portion of the hospitalization prior to the effective date are not covered.

Termination Dates of Coverage

Employee

Your coverage as an Employee under all benefit provisions of the Plan terminates or ends when anyone of the following events first occurs:

1. You fail to meet the requirements for continuing eligibility as shown in the Eligibility Rules (this includes a failure to make any self-payments of contributions in a timely manner); or

2. The coverage classification under which you were continuing your eligibility terminates; or

3. The Plan itself is terminated.

Dependents

Your coverage as a Dependent under all benefit provisions of the Plan terminates or ends when anyone of the following events first occurs:

1. Eligibility for the Employee of whom you are a Dependent is terminated (for reasons other than the receipt of a maximum amount payable); or

2. You fail to meet the definition of Dependent (in this case, your coverage ends on the first of the month following the date you fail to meet the definition of Dependent); or

3. You fail to meet the requirements for continuing eligibility as shown in the Eligibility Rules (this includes a failure to make any self-payments of contributions in a timely manner); or

4. The coverage classification under which you were continuing your eligibility terminates; or

5. The Plan itself is terminated.

Health Insurance Portability and Accountability Act

This Plan does not have a pre-existing condition exclusion. If you have questions about your rights under ERISA or HIPAA, you should contact the nearest office of the Employee Benefits Security Administration, U.S., Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

Family and Medical Leave Act

You may be eligible for up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons under the Family and Medical Leave Act of 1993. Generally, you are eligible under the Act if:

1. You are employed by an Employer with at least 50 Employees at your work site or with at least 50 Employees within a 75-mile radius of your work site;

2. You have been employed by the Employer for at least 12 months; and

3. You have worked at least 1,250 hours for the Employer during the 12 months immediately before the requested leave.

Your Employer determines whether you are eligible for family or medical leave under the Act, not this Plan or its Trustees.

Both you and your Employer are required to notify the Fund Office if you take a family or medical leave and to provide certain other information as required by the Trustees. Your coverage under the Plan will continue during the period of your family or medical leave, provided your Employer makes contributions to the Plan at the same rate and in the same amount as if you were continuously employed during the period of your leave and provided that your Employer fully complies with all requirements established by the Trustees.

CONTINUING COVERAGE UNDER COBRA

This section is intended to explain to you and your Eligible Dependents, in a summary fashion, about rights and obligations under the Continuation Coverage provisions of the Consolidated Omnibus Budget Reconciliation Act or "COBRA." You, your spouse (if any) and your dependents (if any) should take time to read this section carefully.

Certain terms are used in this section and are defined as follows:

Continuation Coverage is the coverage available to you and your family in the event you lose eligibility due to a Qualifying Event. If you elect Continuation Coverage, the Plan must provide coverage, which, as of the time such coverage is provided, is identical to the coverage provided for other similarly situated beneficiaries. However, short-term disability benefits are not provided.

A Qualified Beneficiary is an individual who is covered under the Plan on the day before a Qualifying Event, as well as a newborn child or child placed for adoption with you during the period of Continuation Coverage. Eligible Persons are you or your Eligible Dependent spouse or your Dependent child(ren).

A Qualifying Event is an event that causes you and/or your family to lose coverage under the Plan. The specific events, which are Qualifying Events for you, your spouse and/or your children, are explained in detail in the following sections. Depending on the Qualifying Event, Continuation Coverage is available for 18, 29 or 36 months. In the case of a loss of coverage due to the end of employment (for reasons other than gross misconduct) or a reduction in the hours worked which results in loss of eligibility under the Plan, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an Employee's death, divorce or legal separation, the Employee's becoming entitled to Medicare benefits or a Dependent child ceasing to be Dependent under the terms of the Plan, coverage may be continued for up to a total of 36 months. When the Qualifying Event is the end of employment or reduction of the Employee's hours of employment and the Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Eligible Persons other than the Employee last until 36 months after the date of Medicare entitlement. This notice shows the maximum period of Continuation Coverage available to the Eligible Persons.

Employee Right to Elect Continuation Coverage

You, as an Eligible Person, have the right to choose Continuation Coverage if you lose eligibility for coverage under the Plan due to a reduction in the amount of Employer contributions remitted or termination of employment for any reason, unless termination is due to gross misconduct on your part. Either of those circumstances is what is known as a "Qualifying Event" for you, as an Employee. These Qualifying Events entitle you and/or your family to elect 18 months of Continuation Coverage.

The Trustees, through the Fund Office, determine when a Qualifying Event occurs as a result of a reduction of Employer contributions or a termination of employment based on information contained on submitted Employer contribution forms. The Fund Office will determine when the COBRA Qualifying Event has occurred within 120 days following receipt of the Employer contribution form. The Fund Office will mail the COBRA election notice within 60 days after it has determined that you or your Eligible Dependent has lost eligibility for coverage. You have

60 days from the date you receive the election notice to elect to receive Continuation Coverage. If you do not make an election for coverage within 60 days, you no longer have a right to receive Continuation Coverage.

If you qualify for Continuation Coverage under COBRA but do not elect such coverage for your entire family, your Eligible Dependent spouse and/or Dependent children are still entitled to independently elect Continuation Coverage for themselves.

Your Eligible Dependent Spouse's Right to Elect Continuation Coverage

Eligible Dependent spouses of Employees covered under the Plan, as Eligible Persons, have the right to choose Continuation Coverage for themselves if they lose their group health care coverage under the Plan for any of the following reasons:

- Termination of your employment (for reasons other than gross misconduct) or a reduction in the hours worked by you which results in your losing eligibility under the Fund;
- Your death;
- Divorce or legal separation from you; or
- You become entitled to Medicare and are not eligible to continue coverage for your spouse under another portion of the Plan or choose not to continue such coverage.

These reasons are known as Qualifying Events for your spouse. In the case of losses of coverage due to your death, divorce or legal separation or your becoming entitled to Medicare benefits, coverage may be continued for up to a total of 36 months. In the case of loss of coverage due to the first Qualifying Event (termination of your employment or a reduction in the hours worked by you, which results in their loss of eligibility) your spouse can elect 18 months of Continuation Coverage. If a second Qualifying Event(s) occurs, it would entitle your spouse to elect up to a total of 36 months of Continuation Coverage.

Your Eligible Dependent Children's Right to Elect Continuation Coverage

All of your Eligible Dependent children covered under the Plan, as Eligible Persons, have the right to Continuation Coverage if they lose their eligibility for coverage under the Plan for any of the following five reasons:

- Termination your employment (for reasons other than gross misconduct) or a reduction in the hours worked by you which results in your losing eligibility under the Fund;
- Your death;
- Divorce or legal separation of their parents;
- You become entitled to Medicare and either are not eligible to continue coverage for the children or choose not to continue such coverage; or
- The child or children cease to satisfy the Plan's definition of a "Dependent child."

These reasons are known as Qualifying Events for your Dependent children. In the case of losses of coverage due to an Employee's death, divorce or legal separation, the Employee's becoming entitled to Medicare benefits or an Eligible Dependent child ceasing to be Dependent under the terms of the Plan, coverage may be continued for up to a total of 36 months. In the case of loss of coverage due to the first Qualifying Event (termination of your employment or a reduction in the hours worked by you, which results in their loss of eligibility) your Dependent child(ren) can elect 18 months of Continuation Coverage. If a second Qualifying Event(s) occurs, it would entitle your Dependent child(ren) to elect up to a total of 36 months of Continuation Coverage.

A newborn or adopted child will automatically be extended COBRA coverage if the parents already have COBRA coverage. This may involve an increase in the COBRA premium charged. A newborn child or an adopted child (or the child's custodian or guardian) has a right, separate from his or her parents to elect Continuation Coverage for 18 or 36 months, depending on the Qualifying Event, even if the child's parent(s) do not elect Continuation Coverage.

Continuation Coverage for Disabled Persons

If you, as a covered Employee, your Eligible Dependent spouse or any Dependent child, as Eligible Persons, qualify for Social Security disability benefits at the time of a Qualifying Event that entitles the Eligible Person to elect 18 months of Continuation Coverage (or any time during the first 60 days after you lose coverage due to a Qualifying Event), you may purchase up to an additional 11 months of Continuation Coverage (or a total of 29 months).

This additional Continuation Coverage may be purchased not only for the disabled person but also for other family members who are not disabled (subject to the applicable premium).

To obtain this additional Continuation Coverage, the Eligible Person must be determined eligible for Social Security disability benefits before the end of the 18-month Continuation Coverage period and must notify the Fund Office during the 18-month period and within 60 days after the Social Security Administration awards Social Security benefits to the disabled person.

The Fund is permitted to charge a higher premium (up to 150% of the regular COBRA premium) for the additional 11 months of Continuation Coverage available to disabled persons and their families. The higher premium applies to the disabled person and for other family members who opt for additional COBRA coverage.

Eligibility for extended Continuation Coverage because of disability ends the first day of the month that is more than 30 days after the date that the person is determined under the Social Security Administration to be no longer disabled. Federal law requires a disabled person to notify the Fund within 30 days of a final Social Security Administration determination that they no longer are disabled.

Employee Obligations to Notify the Fund Office of a Qualifying Event

Under COBRA, you or a family member must notify the Fund Office immediately about a divorce, legal separation or a child losing Dependent status under the Plan. If such an event is not reported to the Fund Office within 60 days after it occurs, Continuation Coverage will not be permitted. It is also recommended that the Fund Office be notified in the event of your termination of employment, reduction in hours or your death.

Your surviving Eligible Dependent spouse (or Dependent child) should contact the Fund Office immediately after your death. This assures that Continuation Coverage is offered to your surviving spouse and children at the earliest possible date.

The law requires the COBRA election notice to be sent to the last known address on file at the Fund Office. If the election notice is sent to the wrong address due to your failure to notify the Fund Office about a change in address, the 60-day time limit will not be extended and you may lose the opportunity to elect COBRA.

You are also required to notify the Fund Office if you or any family members are covered under another group health care plan at the time you received a COBRA election notice (e.g., if you are covered as a Dependent under your spouse's plan) or if you elect Continuation Coverage, at any time you or a family member later becomes covered under another group health care plan, including Medicare.

The Fund Office may require you to provide information about your coverage under another group health care plan. The Fund may seek reimbursement directly from you if medical expenses are paid by the Fund because you or your dependents do not notify the Fund of other health care coverage.

Second Qualifying Events

The following rules concerning the occurrence of a second Qualifying Event only apply if the original Qualifying Event was termination of the Employee's employment (for reasons other than gross misconduct) or reduction in the number of hours worked by the Employee. If a second Qualifying Event should occur during the 18 months of coverage available as a result of the first Qualifying Event (or, 29 months if the 11 month extension due to disability applies), then you may purchase additional Continuation Coverage for up to a total of 36 months. An example of a second Qualifying Event would be:

- Death of the Employee, if he or she is a covered Employee under the Plan;
- Divorce or legal separation of the Employee and his/her spouse;
- The Employee, if a covered Employee under the Plan, becomes enrolled in Medicare (Part A, Part B or both); or
- For Eligible Dependent children, the Dependent child ceases to satisfy the Plan's definition of an "Eligible Dependent." (The rules for second Qualifying Events also apply to newborn or adopted children.)

This 36 months total of Continuation Coverage available when a second Qualifying Event occurs includes the number of months you have already been covered under Continuation Coverage because of the first Qualifying Event. The 36-month total is not in addition to any months of Continuation Coverage you have already had because of the first Qualifying Event. The Plan Administrator must be notified within 60 days of the second Qualifying Event or the additional extended coverage will not be allowed.

Proof of Insurability is Not Necessary to Elect Continuation Coverage

You and your family members do not have to show that you are insurable to purchase Continuation Coverage. But, you must make the required self-payment(s) for such coverage in accordance with specific due dates. The amount(s) and the due date(s) will be shown on the COBRA election notice.

Procedure for Obtaining Continuation Coverage

Once the Fund Office knows that an event has occurred which qualifies you or other family members for Continuation Coverage, the Fund Office will attempt to notify you or your family member of their rights to elect Continuation Coverage.

Once you receive this election notice, you will have 60 days after the date on the election notice within which to notify the Fund Office whether or not you want the Continuation Coverage. If you do not elect the coverage within the 60-day time period, your right to continue your group health care coverage will end.

Termination of Continuation Coverage

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid in full on time,
- A covered Employee becomes entitled to Medicare benefits (under Part A, Part B or both) after electing Continuation Coverage or
- The Employer ceases to provide any group health plan for its Employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of an Employee or Eligible Dependent not receiving Continuation Coverage (such as fraud).

Although your Continuation Coverage may be canceled as soon as you are covered by Medicare, a spouse or Dependent child receiving Continuation Coverage at that time may continue purchasing such coverage for up to 18 or 36 months minus any months of Continuation coverage received immediately prior to your coverage under Medicare. This option applies only if a spouse or Dependent child is not also covered by Medicare.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability ACT (HIPPA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

SUMMARY OF BENEFITS

The summaries below give an overview of medical, prescription drug, dental, weekly loss-of-time and life insurance and accidental death and dismemberment (AD&D) benefits for Employees and their Eligible Dependents.

Note: Amounts shown are what you pay.

Medical Benefits

The Plan's Medical benefits are administered by BCBSIL.

The Plan has also contracted with BCBSIL to use its Preferred Provider Organization (PPO) network. In-network providers charge a negotiated rate for services. These rates are typically less expensive than what out-of-network providers charge.

Note that you must first meet your annual deductible before you are eligible to receive benefits unless stated otherwise. Co-payments, amounts you pay above the Allowable Charge, deductibles and amounts you pay for services not covered by the Plan do not apply to the annual deductible or the annual out-of-pocket maximum.

	In-Network	Out-of-Network
Annual Deductible		
Individual	$250	$250
Family	$500	$500
Annual Out-of-Pocket Maximum*		
Individual	$1,250	$2,250
Family	$2,500	$4,500
Coinsurance	10%	• 20% • 50% (Non-Administrative Provider)
Office Visit** • Primary Care Physician • Specialist	$10 co-payment, deductible does not apply	• 20% after $10 co-payment, deductible does not apply • 50% after $10 co-payment, deductible does not apply (Non-Administrative Provider)
DOT Required Physical Exams (Employee only) You must bring the letter found at the end of this SPD with you when getting a DOT physical. The letter contains information and instructions for the provider on how to cover the exam.	No charge, deductible does not apply	No charge, deductible does not apply

	In-Network	Out-of-Network
Preventive Care		
Routine Physical Exam • Routine Mammograms • Routine Pap Smear Tests • Prostate Tests Covered • Digital Rectal Examinations • Colorectal Cancer Screening • Routine Colonoscopy • HPV Vaccine • Shingles Vaccine	No charge, deductible does not apply	No charge, deductible does not apply
Well-Child Care	No charge, deductible does not apply	No charge, deductible does not apply
Tobacco Cessation Program	10% per visit, deductible does not apply, limited to 4 counseling visits per year	
Weight Loss Program	No charge, deductible does not apply, limited to 13 counseling visits per year	
Emergency Care		
Hospital	No charge, deductible does not apply	No charge, deductible does not apply
Physician	No charge, deductible does not apply	No charge, deductible does not apply
Inpatient Hospital		
• Preadmission Testing • Hospice Care	10%	20% • 50% (Non-Administrative Provider)
Outpatient Hospital • Surgery • Diagnostic Services (X-ray, blood work) • Imaging (CT/PET scans, MRIs) • Radiation Therapy, Chemotherapy, Electroconvulsive Therapy • Renal Dialysis Treatment	10%	• 20% • 50% (Non-Administrative Provider)

	In-Network	Out-of-Network
Pregnancy		
• Office Visit, pre- and post-natal care	$10 co-payment then 10%	• 20% • 50% (Non-Administrative Provider)
• Childbirth/delivery professional services • Childbirth/delivery facility services	10%	• 20% • 50% (Non-Administrative Provider)
Rehabilitation Services (Outpatient physical, occupational and speech therapy) (Limited to 60 visits per year)	10%	• 20% • 50% (Non-Administrative Provider)
Mental Health and Substance Abuse	10%, deductible does not apply	• 20%, deductible does not apply • 50% (Non-Administrative Provider), deductible does not apply
Home Health Care (Limited to 50 days per year)	10%	• 20% • 50% (Non-Administrative Provider)
Skilled Nursing	10%	• 20% • 50% (Non-Administrative Provider)
Durable Medical Equipment	10%	• 20% • 50% (Non-Administrative Provider)
Private Duty Nursing		$3,000 per month (not available from Non-Administrative Providers)
Other Benefits		
• Chiropractic • (Limited to 13 visits per person per year and $70 maximum benefit per visit)	• 10% after $10 co-payment	• 20% after $10 co-payment • Not covered (Non-Administrative Provider)
• Vasectomy ($500 lifetime maximum benefit)	• No charge	• No charge • Not covered (Non-Administrative Provider)
• Tubal Ligation ($750 lifetime maximum benefit)	• No charge	• No charge • Not covered (Non-Administrative Provider)
• Abortion	• 10%	• 20% • 50% (Non-Administrative Provider)

	In-Network	Out-of-Network
• Temporomandibular Joint Dysfunction (TMJ) and Related Disorders ($1,000 lifetime maximum benefit)	• 10%	• 20% • 50% (Non-Administrative Provider)
• Orthotics (Limited to one pair every 12 months for adults; one pair once every six months for children under 19 when replacement is medically necessary)	• 10%	• 10%
• Organ Transplants • (Pre-authorization required)	• 10% when performed at Blue Distinction Centers only • 20% when performed by other in-network providers	• Not covered
• Hearing Aids	Limited to a $3,000 allowance per ear, per person every 36 months	

* Note: Annual deductibles, office visit co-payments, prescription drug co-payments, charges for treatment of mental illness (other than serious mental illness), and charges for treatment for drug or alcohol dependency do not apply to the annual out-of-pocket maximum. The annual out-of-pocket maximums are in addition to the annual deductible.

** Please note that if your provider adds charges to an invoice in addition to the Office Visit charge, those charges are paid at the normal Medical coinsurance rates and they are subject to the annual deductible and annual out-of-pocket maximums.

Prescription Drug Benefits

Prescription drug benefits are administered by Prime Therapeutics.

Annual Deductible	None	
Annual Out-of-Pocket Maximum	None	
Retail Pharmacy (34-day supply only)		
	Participating Pharmacy	Non-Participating Pharmacy
Generic	$5 co-payment	25% after $5 co-payment
Brand Name Formulary	$20 co-payment	25% after $20 co-payment
Brand Name Non-Formulary	$40 co-payment	25% after $40 co-payment
Mail Order Pharmacy (90-day supply only)		
Generic	$10 co-payment, no deductible	
Brand Name Formulary	$40 co-payment, no deductible	
Brand Name Non-Formulary	$80 co-payment, no deductible	

See page 47 for more information about prescription drug benefits and formularies.

Dental Benefits

Dental benefits are administered by Delta Dental of Illinois.

	Network Dentist (Delta Dental PPO or Delta Dental Premier)	Non-Network Dentist
Calendar Year Deductible (Combined for network and non-network Dentists)		
Individual	$25	
Family	$75*	
Maximums (Combined for network and non-network Dentists)		
Calendar Year Maximum Benefit**	$1,500 per person	
Calendar Year Orthodontia Maximum Benefit	$1,500 per person	
Preventive Services	No charge	No charge
Diagnostic Services	No charge	No charge
Basic Services	20% after deductible	20% after deductible
Major Dental Services	50% after deductible	50% after deductible
Orthodontia	50% after deductible	50% after deductible

* Once three family members each meet their calendar year deductible, a deductible requirement no longer applies for all covered family members.

** The calendar year maximum benefit does not apply to covered individuals younger than age 18.

Pulp vitality tests are not covered.

Dental implants for ages 18 and over are covered subject to 50% coinsurance.

Vision Benefits

Vision benefits are paid by Vision Service Plans, Inc. (VSP).

Vision Benefit	VSP Provider	Non-VSP Provider
Exam	0%	Up to $25
Frames		
Frame Allowance	Up to $175	Up to $45
Featured Frame Allowance	Up to $195	
Costco Frame Allowance	Up to $95	
Additional discounts	20% off amount over	N/A

Vision Benefit	VSP Provider	Non-VSP Provider
	allowance	
Lens Options		
Single vision	$0	Up to $30
Lined Bifocal	$0	Up to $35
Lined Trifocal	$0	Up to $45
Polycarbonate lenses	$0	N/A
Standard progressive lenses	$50	Up to $45
Premium progressive lenses	$80 - $90	
Custom progressive lenses	$120 - $160	
Contacts		
Contact Allowance (fitting and evaluation)	Up to $175	Up to $105
Additional discounts	15% savings on a contact lens exam (fitting and evaluation)	N/A
Safety Glasses (Employees only)		
Safety Eye Exam	$0	Not available
Safety Eye Frame	Up to $65	Not available
Additional discounts	20% off amount over allowance	Not available
Lenses		
Prescription single vision	$0	Not available
Lined bifocal	$0	Not available
Lined trifocal	$0	Not available
Additional services		
Sunglasses	30% savings on additional glasses and sunglass from same VSP provider on the same day as your WellVision Exam; 20% savings from any VSP provider within 12 months of last WellVision Exam	Not available
Retinal screening (enhancement to WellVision Exams)	Up to $39 copay	Not available
Laser vision	15% off regular price or 5% off promotional price, only available with contracted facilities	Not available

Short-Term Disability Benefit

Short-Term Disability benefits are administered by the Fund Office.

Short-Term Disability	
Non-Occupational Benefit	$300 per week
Maximum Payment Period	26 weeks
Occupational Benefit	Not covered

Life Insurance and Accidental Death & Dismemberment (AD&D) Benefits

Life insurance and Accidental Death & Dismemberment (AD&D) benefits are insured and paid by The Sun Life Insurance Company (“Sun Life”).

Life Insurance	
Active Death Benefit(Employees only)	$40,000
Accidental Death and Dismemberment (AD&D)	
Accidental Death Benefit (for Employees only)	$40,000
Loss of sight of one eye	$20,000
Loss of one limb	$20,000
Loss of speech and hearing	$40,000
Loss of speech or hearing	$20,000
Loss of thumb and index finger of the same hand	$10,000
Quadriplegia	$40,000
Paraplegia	$30,000
Hemiplegia	$20,000
Additional Life and AD&D Benefits	
Business Travel Benefit	The lesser of $25,000 or 25% of the amount of Accidental Death benefit payable
Seat Belt Benefit	The lesser of $25,000 or 25% of the amount of Accidental Death benefit payable
Air Bag Benefit	The lesser of $5,000 or 10% of the amount of Accidental Death benefit payable
Helmet Benefit	The lesser of $25,000 or 50% of the amount of Accidental Death benefit payable
Disappearance Benefit	$40,000 (Sun Life will assume insured is dead and death is a result of an Accidental bodily Injury if insured was in an Accident and was a known passenger, and body is not found within 365 days after the

Life Insurance	
	date of disappearance)
Dependent Child Education Benefit (full-time student at a post-secondary school before reaching age 23 and within 1 year after member's death)	The lesser of 5% of the member's AD&D benefit payable, or incurred expenses, or $2,500.
Dependent Spouse Education Benefit (retraining or developing skills within 1 year after date of member's death	The lesser of the expenses paid directly to school, or $3,000

COVERED SERVICES

The Plan generally covers the following services:

Medical

Preventive Services

1. Routine physical examinations;
2. Immunizations;
3. Routine diagnostic tests, both Hospital and professional services;
4. Gynecological examinations: Limited to one per year in addition to Routine Physical Examination;
5. Routine mammograms;
6. Routine pap smear tests;
7. Prostate tests;
8. Digital rectal examinations;
9. Colorectal examinations;
10. Routine colonoscopies;
11. Tobacco cessation programs: Limited to four visits of tobacco counseling per year;
12. Weight loss counseling: Limited to 13 visits per year for Physician-prescribed intensive behavioral counseling for weight management;

Inpatient Hospital/facility services (requires pre-authorization)

13. Room and board and ancillary charges in a Hospital, skilled nursing facility (extended care facility), mental health/substance use disorder facilities;
14. Preadmission testing;
15. Coordinated home care and care in a hospice program;

Outpatient Hospital/facility services

16. Surgery;
17. Radiation therapy;
18. Chemotherapy;

19. Electroconvulsive therapy;

20. Urgent care;

21. Renal dialysis treatments;

22. Diagnostic services;

23. Cardiac rehabilitation;

24. Mental health and substance use disorder services

25. Physical, occupational and speech therapies: Limited to 60 visits per year;

Professional services

26. Allergy injections and allergy testing;

27. Anesthesia;

28. Assistance at surgery;

29. Bone mass measurement and osteoporosis services

30. Cardiac rehabilitation services

31. Certain oral surgery procedures;

32. Chemotherapy;

33. Diagnostic services (X-ray/lab work);

34. Durable Medical Equipment;

35. Home infusion therapy;

36. Inpatient consultations;

37. Medical care visits (Inpatient/Outpatient);

38. Chiropractic and osteopathic manipulations: Limited to $70 maximum benefit per visit. Limited to 13 visits per year.

39. Ovarian cancer screening;

40. Occupational, physical and speech therapy: Limited to 60 visits per year;

41. Radiation therapy;

42. Renal dialysis treatments;

43. Electroconvulsive therapy;

44. Leg, back, arm and neck braces;

45. Oxygen and its administration;

46. Prosthetic appliances;

47. Surgery;

Ambulance Transportation Services

48. Local ground or air transportation to the nearest appropriately equipped facility

    a. local ambulance coverage is limited to the first trip to the hospital

    b. long distance transportation coverage is limited to the first trip to the hospital and is provided only if:

        i. the attending doctor certifies that the disability requires specialized or unique treatment that is not available in a local hospital; and

        ii. transportation is provided by a regularly scheduled airline or by a professional air ambulance from the town where the injury occurred to the nearest hospital qualified to provide the special treatment; and

        iii. the transportation is limited to the U.S., Mexico or Canada.

Other Services

49. Contraceptive services

    a. Female prescription contraceptive devices, injections, implants, consultations, examinations, procedures and medical services;

    b. Tubal ligation

    c. Vasectomy

50. Maternity care

51. Emergency medical and emergency Accident care

52. Blood and blood components;

53. Dental Accident care;

54. Medical and surgical dressings;

55. Private duty nursing (requires pre-authorization): Limited to $3,000 per month;

56. Supplies, cast and splints;

57. Continuous glucose monitor, insulin pump and related services;

58. Human organ and tissue transplants for heart, lung, heart/lung, liver, pancreas or pancreas/kidney: Limited to BCBS-approved programs only and requires pre-authorization;

59. Temporomandibular Joint Dysfunction (TMJ) services: Limited to $1,000 maximum benefit per year

60. Wigs or hairpieces prescribed by a physician as a prosthetic for hair loss due to cancer: Limited to one wig per lifetime, up to a $1,500 maximum benefit.

Mental health benefits (requires preauthorization)

61. Inpatient and Outpatient treatment rendered by:

    a. A Hospital;

    b. Substance use disorder treatment facility;

    c. Partial Hospitalization (day/night) treatment program;

    d. Intensive Outpatient program;

    e. Physician;

    f. Psychologist;

    g. Licensed clinical social worker;

    h. Licensed clinical professional counselor;

    i. Licensed marriage and family therapist; and,

62. Substance abuse/chemical dependency services: Limited to Employee and Eligible Dependent spouse only.

Prescription Drugs

1. Generic and brand-name prescription drugs;

    a. Insulin and insulin syringes;

    b. Diabetic glucose monitors and strips;

    c. Self-injectables

    d. Contraceptives, including oral contraceptives, rings and patches

    e. Smoking cessation drugs;

    f. Weight loss drugs;

    g. Prenatal vitamins;

    h. Sexual dysfunction drugs, up eight pills per month;

    i. Infertility drugs;

    j. Migraine medication;

k. Acne treatments (requires pre-authorization);

l. Growth hormones (requires pre-authorization);

m. Antifungals;

n. Anabolic steroids (requires pre-authorization);

o. Anti-inflammatory medication;

p. Transplant/immunosuppressive medication;

q. Compound drugs;

r. Non-sedating antihistamine drugs;

s. Proton pump inhibitors (PPIs);

t. Attention Deficit Disorder (ADD) medication.

Dental

Preventive Services

1. Dental prophylaxis (cleaning): Limited to twice per calendar year; with an indicator for diabetes, high-risk cardiac conditions, or kidney failure or dialysis conditions, the Eligible Person will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year. With an indicator for periodontal disease, the Eligible Person will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in the Summary of Benefits. With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the Eligible Person will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in the Summary of Benefits. With an indicator for Pregnancy, the Eligible Person will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of Pregnancy.
2. Topical fluoride applications: Limited to once per calendar year; for Dependent children under age 19;
3. Space maintainers: Limited to once per lifetime for Eligible Dependent children under age 16;
4. Recementation of space maintainers: Limited to once per lifetime for Eligible Dependent children under age 16;
5. Sealants: Limited to Eligible Dependent children under age 16; applied once per tooth to first and second permanent molars which are free of cavities and restorations.

Diagnostic Services

6. Oral evaluations (includes limited problem-focused and re-evaluation);
7. Comprehensive, detailed and extensive oral or periodontal evaluation: Limited to new or established patient only and limited to once per Dentist. If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be

limited to that of a periodic oral evaluation. Detailed or comprehensive oral evaluations count toward the calendar year maximum of two oral evaluations.

8. Periodic oral evaluations: Limited to twice per calendar year;
9. Intraoral periapical radiographs;
10. Bitewing X-rays: Limited to twice per calendar year;
11. Complete full mouth X-rays: Limited to one every 36 months; A full mouth X-ray includes bitewing X-rays. Panoramic X-rays in conjunction with any other X-ray, or any combination of intraoral X-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth X-ray, is considered a full mouth X-ray. One full-mouth X-ray or one panoramic X-ray is a covered benefit in a 36-month interval.
12. Diagnostic casts: Covered only when rendered more than 30 days prior to definitive treatment.

Restorative Services

13. Amalgam and anterior resin-based composite fillings: Limited to once per surface in a 12-month interval. When a resin filling is placed on a molar or premolar (except on the facial surface of a pre-molar), the level of benefits will be limited to that of an amalgam filling. When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling.
14. Onlays: Limited to permanent teeth only;
15. Crowns and ceramic restorations: Limited to permanent teeth only;
16. Recementation of inlays, onlays, partial coverage restorations, cast or refabricated posts and cores and crowns;
17. Prefabricated stainless steel and resin crowns;
18. Crown repair;
19. Sedative filling: Sedative fillings are covered once per tooth per lifetime.
20. Pin retention: When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.
21. Additional procedures to construct new crown under existing partial denture framework.

Endodontic Services

22. Pulpal and root canal therapy: Limited to once per tooth per lifetime. When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure. When incomplete endodontic therapy is billed because the patient has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pulpal debridement.
23. Pulp cap: Limited to once per lifetime.

Surgical Periodontic Services

24. Gingivectomy or gingivoplasty: Limited to once per 12 months;

25. Gingival flap procedure: Limited to once per 36 months;

26. Clinical crown lengthening, hard tissue: Limited to once per 12 months;

27. Osseous surgery (including flap entry and closure): Limited to once per 36 months;

28. Guided tissue regeneration, per site: Limited to only when performed in association with natural teeth;

29. Bone replacement grafts: Limited to once per lifetime;

30. Soft tissue grafts: Limited to once per 36 months;

31. Distal or proximal wedge procedure: Limited to once per 36 months.

Non-Surgical Periodontic Services

32. Periodontal scaling and root planing

33. Full mouth debridement to enable comprehensive evaluation and Diagnosis: Limited to once per 36 months;

34. Periodontal maintenance: Limited to twice per calendar year. Periodontal therapy includes treatment for diseases of the gums and bone supporting the teeth once per quadrant in any 36-month interval. Periodontal maintenance is only covered with a history of periodontal therapy.

Removable Prosthodontic Services

35. Complete and partial dentures, including adjustments and repairs: When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 60 months following placement of the initial appliance is not a covered benefit. When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of one pontic per missing tooth. When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.

36. Replacement of missing or broken teeth;

37. Adding tooth or clasp to existing partial denture;

38. Replacement of all teeth and acrylic on cast metal framework;

39. Denture rebase or reline: Limited to once in a 24-month interval.

Fixed Prosthodontic Services (Bridges)

40. Pontics;

41. Fixed partial denture retainers inlays/onlays inlays/onlays placed as abutments, i.e., to retain or support fixed partial dentures) and crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures): When a porcelain/ceramic inlay is requested or placed as an abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.

42. Recement fixed partial denture;

43. Cast or prefabricated post and core; core build-up;

44. Fixed partial denture (bridge) repair: If, in the construction of a prosthodontic appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontic appliance.

Oral Surgery

45. Simple extractions;

46. Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth;

47. Removal of completely bony impacted tooth;

48. Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus;

49. Surgical access of an unerupted tooth;

50. Biopsy of oral tissue including brush biopsy;

51. Alveoloplasty (per quadrant);

52. Vestibuloplasty (ridge extension);

53. Surgical excision of soft tissue lesions and intra-osseous lesions;

54. Other covered surgical/repair procedures: removal of exostosis, torus palatinus or torus mandibularis;maxillary sinusotomy for removal of tooth fragment or foreign body; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity; sialolithotomy; excision of salivary gland; closure of salivary fistula.

Adjunctive General Services

55. Minor procedures resulting from palliative (emergency) treatment of dental pain

56. Deep sedation/general anesthesia: When provided by a Dentist in conjunction with Endodontic Services, Periodontic Services and Oral Surgery (Surgical Procedures) other than simple extractions;

57. Intravenous conscious sedation/analgesia: When provided in conjunction with Endodontic Services, Periodontic Services and Oral Surgery (Surgical Procedures) other than simple extractions;

58. Consultations.

Other Services

59. Fixed and removable appliances to inhibit thumbsucking: Limited to once per lifetime for Dependent children under age 14;

60. Intramuscular sedation;

61. Nitrous oxide;

62. Tissue conditioning: Limited to once per 12 months;

63. Occlusal guard: Limited to once per lifetime;

64. Occlusal adjustment: Limited to once per 12 months

65. Implants;

66. Implant repair: Limited to once per lifetime;

67. Implant removal: Limited to once per lifetime;

68. Labial veneers: Limited to once per 60 months.

Orthodontic Services

69. Orthodontia: Defined as treatment necessary for the proper alignment of teeth. Available to all Eligible Persons.

GENERAL PLAN PROVISIONS

Medical Benefits

"In-network" means a Hospital or Physician that has an agreement with BCBSIL or a Blue Cross Plan of another state to provide Hospital or Physician services to Eligible Persons in the Participating Provider Option (PPO") program.

"Out-of-network" means a Hospital or Physician that has an agreement with BCBSIL or a Blue Cross Plan of another state to provide Hospital or Physician services to Eligible Persons but, which does **not** participate in the PPO program.

"Non-Administrator Provider" means a Hospital or Physician, which does not have **any** written agreement with BCBSIL or a Blue Cross Plan of another state to provide services to you at the time services are rendered to you.

When an Eligible Person obtains services from a PPO network provider, the Plan pays 90% of the Allowable Charges above the deductible and the Eligible Person is only responsible for 10% of those charges. The Eligible Person is not responsible for any charges above the Allowable Charge.

If you visit an in-network provider, the provider is obligated to charge you a certain amount. For example, you visit an in-network cardiologist, who would normally charge $500 for the visit. In this case, however, the Plan's Allowable Charge is only $100. Because the provider is in the network, you are responsible for paying 10% of the Allowable Charge, or $10.

If an Eligible Person obtains services from a provider outside of the PPO network (or from a Non-Administrator Provider) the Plan pays only 80% (or 50%) of the Allowable Charges above the deductible. The Eligible Person is then responsible for 20% (or 50%) of those charges. The Plan cannot prevent the non-PPO provider from billing the Eligible Person for the balance of the charges over the Allowable Charge.

For example, let's say the cardiologist from the example above is an out-of-network provider. The cardiologist still charges $500 for the visit, but the Plan only covers up to the Allowable Charge, or $100. You must pay 20% of the Allowable Charge, or $20. However, because the provider is out-of-network, the cardiologist can also charge you for the balance between the Allowable Charge and the actual charge, or $400 ($500 - $100). This practice is called **balance billing**. In this example, you would be responsible for paying the $20 **and** the $400 balance, for a total of $420.

The out-of-pocket maximum figures are **in addition to** your deductible. Charges for prescription drugs and office visit co-payments are not included within the out-of-pocket maximums.

After you reach the out-of-pocket maximum for the year, the Plan pays at 100% of Allowable Charges. There is no lifetime maximum benefit limit for essential benefits.

Payment for professional services will be based upon a schedule of maximum allowances.

Plan co-payments for the balance of the office visit charges are limited to Allowable Charges.

Department of Transportation (DOT) Physical Exams

Physical exams required by the Department of Transportation (DOT) are covered fully by the Plan and are not subject to the deductible, meaning you pay nothing. Coverage for DOT physicals is for Employees only. Coverage for DOT physicals is provided certain procedures are followed.

- When you go for a DOT physical, present your BCBSIL ID card and have the Physician's office copy the front and back of the card.
- The Physician should call the toll-free number on the back of the card (800-367-8309) to verify Plan membership and benefits for DOT physicals.
- Ask the Physician to use covered procedure codes 99450, 99455 or 99456.

Most health care plans do not cover DOT physicals. Because this is such a unique benefit, many Physicians may try to have you pay for your DOT physical at the time of service. Getting your DOT Physicals paid by BCBSIL should not be a problem if you follow the guidelines stated above.

As an added measure, we suggest taking the letter found at the end of this SPD with you when getting a DOT physical. The letter contains the information found above and provides instructions for covering the exam.

Organ Transplant Services at Blue Distinction Centers

Organ transplants require pre-authorization from BCBSIL and are covered only when performed by an in-network provider.

You may elect to receive organ transplant services at BCBSIL Blue Distinction Centers. These Centers are facilities that have been recognized by BCBSIL for meeting rigorous standards in delivering quality care for better patient safety outcomes and cost efficiency.

For organ transplant services received at Blue Distinction centers, you pay 10% coinsurance (after meeting the annual deductible). If you receive organ transplant services at other in-network facilities, you pay 20% coinsurance (after meeting your annual deductible).

Organ transplant services received at an out-of-network facility will not be covered.

Mental Health and Substance Abuse Treatment

The Member Assistance Program is provided by Employee Resource Systems, Inc. (ERS). You should contact ERS by calling (800) 292-2780 before you seek treatment for mental or nervous disorder treatment.

Note: Mental and Nervous Disorders are considered mental illnesses and the term Mental Illness is divided into two categories: Serious Mental Illness and Other Than Serious Mental Illness. The definitions are defined as follows:

Mental Illness means those illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"Serious Mental Illness" means the following mental disorders as classified in the current Diagnostic and Statistical Manual published by the American Psychiatric Association:

1. Schizophrenia;
2. Paranoid and other psychotic disorders;
3. Bipolar disorders (hypomanic, manic, depressive and mixed);
4. Major depressive disorders (single episode or recurrent);
5. Schizoaffective disorders (bipolar or depressive);
6. Pervasive developmental disorders;
7. Obsessive-compulsive disorders;
8. Depression in childhood and adolescence; and
9. Panic disorder.

Alcoholism or Substance Abuse Treatment (Employees only)

The Plan has contracted with ERS to provide assistance to Employees who test positive for drug or alcohol use pursuant to United States Department of Transportation (U.S. DOT) testing requirements. Coverage for assistance with treatment consistent with U.S. DOT regulations must be obtained through ERS.

Employees who perform work, regulated by the DOT (such as those who have a Commercial Driver's License [CDL]), should contact ERS after being informed that they have tested positive on a required drug test and/or prior to seeking treatment for any substance use disorder. The services of a Substance Abuse Professional (SAP) are available to Eligible Employees through the Member Assistance Program.

Member Assistance Program (MAP)

Our fast-paced society has a direct impact on how we function at home and on the job. Most people experience personal issues at one point or another during their lifetime. Issues can include anxiety, depression, alcohol and drug abuse, financial or legal matters, career, marital or family concerns, and adjustment to an illness.

Employee Resource Systems, Inc. (ERS), provides a confidential Member Assistance Program for you and your Eligible Dependents. The MAP's role is to help you cope with personal concerns and serve as a resource in locating further assistance when needed.

Using the MAP

Call the MAP at (800) 292-2780. Trained ERS counselors will respond to your request for help. When you call, you will be connected to an accredited clinician who will guide you through the MAP process and manage every aspect of your case. You may speak with a MAP counselor over the phone and you will be offered an in-person assessment at an office convenient to you.

The MAP case manager will discuss your needs and the reason for calling or meeting, and will then match you with an ERS affiliate with the appropriate specialty. The MAP will confirm the affiliate's availability and provide you with contact information to confirm your appointment.

During the assessment, if it becomes apparent that brief counseling is either inappropriate or insufficient to address your concerns, the counselor will guide you to an in-network provider or facility and the appropriate level of care. MAP counselors work with to you understand your benefits when care extends beyond the MAP.

The MAP counselor will maintain contact with you until it is agreed that your concerns and issues have been addressed.

The MAP is available to you and your Eligible Dependents while enrolled in the Plan.

The Member Assistance Program provides a comprehensive work-life program to assist you and your Eligible Dependents in the areas of Daily Living, Family & Caregiving, Emotional Well-being, Health & Wellness and Working Smarter. By visiting www.ers-eap.com and entering the username: **tree** and the password: **trimmer**, you and your Eligible Dependents can access 24/7 Work-Life consultants via the internet and LiveConnect online instant messaging. The Work-Life website is loaded with content and tools for managing work, personal and everyday issues.

Confidentiality

Confidentiality is the most important aspect of a MAP. All information shared with the MAP counselor will be held in the strictest confidence. In the event that a third party such as a referral source or supervisor must be consulted, a release of information form will be obtained from the MAP client. The MAP counselors uphold confidentiality as governed by state law as well as a professional code of ethics.

MAP Cost

As a prepaid benefit, the MAP is provided at no cost to you or your Eligible Dependents. You may receive up to eight free sessions from MAP-approved counselors. However, in the event you are referred for additional help outside the MAP, costs for these services will be your responsibility. The MAP will attempt to find the best resources available, and will attempt to keep your potential costs as reasonable as possible.

How the MAP Can Help

Examples of problem areas the MAP can assist with include, but are not limited to:

- Alcohol/Drug Abuse
- Stress/Anxiety/Depression
- Legal Concerns Financial Concerns
- Education/Career
- Child Abuse/Elder Care
- Domestic Violence
- Marital/Family/Relationships

The MAP does not get involved in difficulties related to work-related issues.

To reach the MAP or get additional information, call 1-800-292-2780 or visit the MAP's website at www.ers-eap.com. We hope you will utilize this valuable resource.

Prescription Drug Benefits

Prescription drug benefits are administered by Prime Therapeutics.

The co-payment that the Plan pays for prescription drugs is based on the drug's category. Prescription drugs are grouped into three categories:

1. Generic Drugs
2. Brand Name Formulary Drugs
3. Brand Name Non-Formulary Drugs

A "Formulary" is a list of drugs. The Formulary will list both a drug's Brand Name and its "Generic" name. The Plan will use a Pharmacy Benefit Manager that will publish the Formulary and you should consult the Formulary to determine how much you will pay for a certain prescription drug.

Eligible Persons must use Prime Therapeutics Specialty Pharmacy for all specialty pharmacy medications.

Pre-Authorization for Specialty Medications

The use of specialty medications requires pre-authorization (sometimes called prior authorization or prior approval). The pre-authorization program is administered by Prime Therapeutics and helps ensure that you take the correct and most cost-effective medications. Prescriptions for specialty medications require a clinical review prior to being filled. If you do not receive pre-authorization, your prescription will not be covered and you will not receive benefits under the Plan. Prime Therapeutics will provide a clinical review to assess the appropriateness of the medication selection, dosage, cost effectiveness and compliance.

To obtain prior approval from Prime Therapeutics, you or your provider must first contact Prime Therapeutics.

What is a Specialty Medication?

When you have a chronic or difficult health condition, like multiple sclerosis or rheumatoid arthritis, you may need specialty medications. Specialty medications are high-cost prescription medications that often require special handling (like refrigeration during shipping), administration (such as injection or infusion) or monitoring.

Dental Benefits

Dental benefits are administered by Delta Dental of Illinois.

Delta Dental of Illinois offers two networks of participating Dentists—the Delta Dental PPO and the Delta Dental Premier® networks. The networks are two of the largest in Illinois and have more than 117,000 participating Dentists nationwide.

How the Dental Program Works

Eligible Persons may go to any licensed Dentist, regardless of whether the Dentist participates in either of the Delta Dental networks, to receive dental care up to the individual annual maximum.

ToGo℠ Carryover Feature

You can take the qualified unused portion of your calendar year maximum benefit "to go" and carry it over from one year to the next. This is called the ToGo Carryover Feature. You are eligible to use this feature as long as you are covered under the Plan for the full benefit plan year, and you submit at least one claim during that benefit plan year which applies toward the calendar year maximum benefit. The most your calendar year maximum benefit can be—regular plus ToGo Carryover amounts combined—is $3,000.

The Delta Dental Networks

Although you may use any Dentist you wish, you will likely save money if you use a Dentist that participates in either the Delta Dental PPO network or the Delta Dental Premier network.

All of Delta Dental's participating Dentists will complete and file claims on your behalf. The Fund will pay the Dentists, through Delta Dental, directly.

If you want the names of participating Delta Dental providers in your area you can:

- Access a Dentist directory on the IBEW Local No. 9 website at www.ibew91ctt.org or
- Contact Delta Dental Customer Service at 800-323-1743 to find participating providers near you.

Vision Benefits

Vision benefits are paid by Vision Service Plans, Inc. (VSP). Your vision benefits include reimbursements and discounts for prescription glasses and contact lenses, sunglasses, eye exams and laser vision corrective surgery.

While you may obtain lenses and frames from any licensed provider, you may receive a more substantial discount by visiting a provider in the VSP network.

You may also receive reimbursement for purchasing safety glasses. The safety glasses benefit applies to the Employee only.

Short-Term Disability Benefits (For Employees Only)

Short-Term Disability benefits (also known as Weekly Loss of Time or Weekly Accident and Sickness benefits) are paid by the Fund Office.

Short-Term Disability benefits only cover non-occupational disabilities for Employees only; that is, injuries or illnesses that occur outside of the workplace and are not work-related. Work-related injuries or illnesses are not covered under this benefit but may be covered under your state's Workers' Compensation laws.

If you become disabled due to a non-occupational illness, your Short-Term Disability benefits begin on the start of the eighth day of your disability.

If you become disabled due to a non-occupational Accident or are confined to a Hospital due to a non-occupational Accident or illness, your benefits begin on the first day of disability.

The weekly Short-Term Disability benefit is $300. Short-Term Disability benefits last for up to 26 consecutive weeks.

Life Insurance and Accidental Death & Dismemberment (AD&D) Benefits

Life Insurance and Accidental Death & Dismemberment (AD&D) benefits are insured and paid by The Sun Life Insurance Company (Sun Life).

OTHER PLAN PROVISIONS

Physical or Dental Examination and Autopsy

The Board of Trustees has the right and shall have the opportunity to examine the person of any individual whose injury or Sickness is the basis of a claim. Such examination shall be at the Board's expense and shall be performed when and as often as it may reasonably require if a claim has been filed under the Plan.

Free Choice of Physician

The covered person has free choice of any Physician and the Physician-patient relationship will be maintained.

Workers' Compensation Not Affected

The Plan is not in lieu of and does not affect any requirement for coverage of Workers' Compensation insurance or coverage.

No Right to Employment

The Plan and this SPD shall not be construed to give you any right to be retained in the Company's employ nor any right or claim to a benefit unless the right to such benefit is in accordance with the Plan's terms.

Circumstances That May Result in Loss of Eligibility or Benefits

Throughout this booklet, the Trustees have tried to bring to your attention those circumstances, which might lead to a loss of eligibility and to describe any limitations, exclusions or restrictions applicable to specified benefits.

The Trustees urge you to familiarize yourself with this information, especially as it relates to the requirements that must be met in order to maintain your eligibility for benefits.

Remember, you must work the required number of hours or make timely self-payments in order to maintain your eligibility.

If at any time you are uncertain about how specific circumstances might affect your eligibility or benefit coverage, please contact the Fund Office and, if possible, try to do so before those circumstances arise.

Women’s Health and Cancer Rights Act Of 1998 (WHCRA)

You or your Eligible Dependents may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For Eligible Persons receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, co-payment and coinsurance applicable to other medical and surgical benefits provided under the Plan. For more information on WHCRA benefits, contact the Fund Office.

COORDINATION OF BENEFITS

To alleviate the problem of duplicate coverage, which needlessly increases the costs of protection, all of the Plan's benefits will be coordinated with the following types of plans. For purposes of Coordination of Benefits only, it is important to distinguish between the “Plan" and other "plans." The “Plan" will refer to the IBEW Local No. 9 and Line Clearance Contractors Health & Welfare Fund. However, "plan" will mean any of the following:

1. Group Insurance or group-type insurance (for example individually underwritten group insurance), whether insured or uninsured (self-funded), blanket, franchise, general liability and common carrier insurance coverage;

2. Hospital or medical service organizations, group practice, individual practice and other pre-payment coverage;

3. Labor-management trust plans, Union welfare plans, Employer organization plans and Employee benefit organization plans; and,

4. Government plans or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301 et seq.), as amended from time to time).

The Plan does not coordinate benefits with individual insurance plans, such as plans found in state or federal health insurance exchanges. If an Eligible Person is covered by this Plan and an individual insurance plan, the individual insurance plan is the primary payer and this Plan is the secondary payer.

Benefits will be reduced under certain circumstances when an individual is covered under this Plan and under one or more other plans or types of coverage, but it is intended that the individual will be fully reimbursed for allowable expenses under the various plans to the extent combined benefits equal one hundred (100%) percent of the total allowable expenses.

Order of Benefit Determination

As stated above, the Plan will coordinate benefits with all plans providing coverage to the Employee or Eligible Dependent for all claims.

1. When the other plan does not have a provision for Coordination of Benefits, it must be considered the primary carrier and this Plan will be secondary to such coverage. Such other plan must make payment first before this Plan will consider payment.

2. When the other plan does have a provision for Coordination of Benefits, the order of benefit payments will be determined as follows:

The Eligible Person must claim benefits due from the "primary" plan determined by these rules for its share of eligible expenses, including benefits or services available from prepayment coverage programs such as Health Maintenance Organizations. When this Plan is "secondary" according to the established order of benefit determination, the term "benefits payable under another plan" will include the benefits that would have been paid if the Eligible Person had made a proper claim on that plan or used its services. This Plan's liability and its benefit

payments will not increase simply because the Eligible Person elects not to use the "primary" coverage.

Order of Benefit Determination Rules

This Plan determines its order of benefits using the first of the following rules, which applies:

Rule 1: Employee/Dependent rule. The plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) are primary to those of the plan which covers the person as a Dependent. Except, if the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is: (a) secondary to the plan covering the person as a dependent; and (b) primary to the plan covering the person as other than a dependent (for example, a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

Rule 2a: Dependent Child rule. This rule applies only if the Dependent child's parents are not separated or divorced. If the child's parents are separated or divorced, please refer to Rules 2b and 2c and to the section below entitled Qualified Medical Child Support Orders.

The benefits of the plan of the parent whose birthday falls earlier in a year are primary to those of the plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the plan which covered the parent longer are primary to those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in Rule 2 immediately above, but instead has a rule based upon the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

Rule 2b: Dependent Child rule. This rule applies if the Dependent child's parents are separated or divorced, no Qualified Medical Child Support Order exists and there is no joint custody as defined in Rule 2c below. If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

1. First, the plan of the parent with custody of the child;

2. Second, the plan of the spouse of the parent with the custody of the child; and

3. Finally, the plan of the parent not having custody of the child.

Rule 2c: Dependent Child Rule. This rule applies if the Dependent child's parents are separated or divorced, no Qualified Medical Child Support Order exists and there is joint custody. If the specific terms of a court decree state that the parents shall share joint custody, the plans covering the child shall follow the order of benefit determination rules outlined in Rule 2a above.

If an adult child is covered under both his or her spouse’s Employer’s plan and the child’s parent’s plan, the plan with the earliest effective date will be primary. If the effective date is the same for both plans, then the birthday rule under Rule 2a shall be used but substituting the spouse for the parent who is covered as an Eligible Dependent under the Plan.

Rule 3: Active Employee rule. The benefits of the plan that covers a person who is an active Employee, who is neither laid off nor retired (or as that Employee's Dependent), are determined before those of the plan which covers the person as a laid off or retired Employee (or as that

Employee's Dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this Rule is ignored.

Rule 4: Continuation Coverage rule. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

First, the benefits of the plan covering the person as an Employee, member or subscriber (or as that person's Dependent);

Second, the benefits of the plan covering the person under the continuation coverage.

If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this Rule is ignored.

Rule 5: Longer Length of Coverage rule. If none of the above rules determines the order of benefits, the benefits of the plan that covered an Employee, member or subscriber longer are determined before those of the Plan, which covered that person for the shorter term.

Qualified Medical Child Support Orders

In the event of a divorce and/or remarriage, the financial and medical responsibility for Eligible Dependent medical coverage may be addressed by court order. However, unless the court order is a Qualified Medical Child Support Order, which means it has been "qualified" by the Plan Administrator, it may not be enforceable. Employees are required to submit certain legal documents requested by the Fund Office in such an event so that the order of benefit determination can be established. Please contact the Fund Office for further information.

Effect on the Benefits of this Plan

When this Plan is secondary pursuant to the "Order of Benefit Determination Rules" or "Coordination of Benefits Rules" outlined above, the benefits paid by this Plan may be reduced according to the terms of this section. Such other plan or plans are referred to as "the other plans" below.

The reduction in this Plan's benefits: The benefits of this Plan will be reduced when the sum of (1) and (2) below exceeds the Allowable Expenses in a Claim Determination Period.

1. The benefits that would have been payable as an Allowable Expense under this Plan in the absence of this COB provision.

2. The benefits that would be payable as Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made.

In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these Coordination of Benefits Rules ("COB rules"). The Board of Trustees has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Board of Trustees need not tell or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Board of Trustees any facts it needs to pay the claim.

Facility of Payment

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Board of Trustees may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Board of Trustees will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Board of Trustees is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Assignment

No assignment of benefits shall assign more than the assignor's right to payment of benefits and shall not be deemed to assign any other right or interest that the assignor has under the Plan (such as the right to appeal or receive documents). No assignment of any present or future right, interest, or benefit under the Plan shall bind the Trustees without their written consent thereto, including the right to bring a suit for payment of benefits.

BENEFITS FOR MEDICARE-ELIGIBLE COVERED PERSONS

This section describes the benefits, which will be provided for:

- Employees (Employees means persons actively employed by an Employer as defined by this document in the Definitions section) who are also Medicare-eligible who are not affected by Medicare Second Payor (MSP) laws, unless otherwise specified in this Summary Plan Description booklet (see provisions entitled "Medicare-Eligible Covered Persons" below.)

- Retirees who are covered under the Plan according to the 24-month extension of benefits for retirees provision described on page 17.

The benefits and provisions described throughout this booklet apply to you, however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Plan is as follows:

1. Determine what the payment for a Covered Service would be following the payment provisions of this coverage and

2. Deduct from this resulting amount the amount paid or payable by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.) The difference, if any, is the amount that will be paid under the Plan.

When you have a claim, you must send the Claims Paying Agent a copy of your Explanation of Medicare Benefits (EOMB) in order for your claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

Medicare-Eligible Covered Persons

If you meet the eligibility requirements as stated in the “Eligibility” section above and you are eligible for Medicare and not affected by the MSP laws as described below, the benefits described in the section of the this Summary Plan Description booklet entitled "Benefits for Medicare-Eligible Covered Persons" will apply to you and to your spouse and to your covered Dependent children (if he or she is also eligible for Medicare and not affected by the Medicare Secondary Payer laws).

A series of federal laws collectively referred to as the MSP laws regulate the manner in which certain Employers may offer group health care coverage to Medicare-eligible Employees, spouses and in some cases, Dependent children.

The statutory requirements and rules for Medicare Secondary Payor coverage vary depending on the basis for Medicare and the Employer's group health plan (GHP) coverage, as well as certain other factors, including the size of the Employers sponsoring the group health plan coverage. In general, Medicare pays secondary to the following:

1. Group Health Plans that cover individuals with end-stage renal disease (ESRD) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of Employees employed by the Employer or whether the individual has "current employment status."

2. In the case of individuals age 65 or over, group health plans of Employers that employ 20 or more Employees if that individual or the individual's spouse (of any age) has "current employment status." This Plan is a multi-Employer plan therefore, if it has at least one contributing or participating Employer that employs 20 or more Employees, the Medicare Secondary Payor rules apply even with respect to those Employers of fewer than 20 Employees. This Plan has not elected the small Employer exception under the statute.

3. In the case of disabled individuals under age 65, group health plans of Employers that employ 100 or more Employees, if the individual or a member of the individual's family has "current Employee status." This Plan is a multi-Employer plan therefore, if it has at least one contributing or participating Employer that employs 100 or more Employees, the Medicare Secondary Payor rules apply even with respect to Employers of fewer than 100 Employees.

Please note: See your Employer or the Plan administrator should you have any questions regarding the end stage renal disease primary period or other provisions of Medicare Secondary Payor laws and their application to you or your Eligible Dependents.

Your MSP Responsibilities

In order to assist your Employer in complying with Medicare Secondary Payor laws, it is very important that you promptly and accurately complete any requests for information from the Fund Office regarding the Medicare eligibility of you, your spouse and covered Dependent children. In addition, if you, your spouse or covered Dependent child becomes eligible for Medicare or has Medicare eligibility terminated or changed, please contact your Employer or the Fund Administrator promptly to ensure that your claims are processed in accordance with applicable Medicare Secondary Payor laws.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to all benefits provided by the Fund. Routine Care and Elective Procedures Benefits under this Plan are for the treatment of Sickness or Accidental Bodily Injury when rendered by Hospitals and Physicians. Routine care, cosmetic surgery* and diet medication or supplements (which are not medically necessary to correct a condition that threatens the health of an Eligible Person) are not eligible for benefits from this Plan. The Trustees reserve the right to have an Eligible Person examined by a Physician of the Trustees choice and at the Trustees expense in order to assist them in making a determination regarding a claim for benefits or for eligibility under the Plan.

Treatment designed to merely improve bodily functions is not considered medically necessary or an eligible expense for benefits. Examples of treatment considered not covered (by way of illustration and not limitation) include: radial keratotomy (to improve sight), and treatment to improve fertility (including, but not limited to, drug/hormone therapy, Surgical Procedures, artificial insemination, in vitro fertilization, embryo transfer procedures and related diagnostic testing of all types).

*Note: The cosmetic surgery exclusion does not apply to coverage mandated by the Women's Health and Cancer Rights Act. Under that Act, if a mastectomy is performed, the Plan will cover reconstructive surgery, including surgery to produce a symmetrical appearance, a prostheses and treatment for lymphedema. Also, the infertility treatment exclusion does not apply to infertility drugs covered under the Prescription Drug benefit.

Medical Necessity

Benefits under this Plan are payable only for services and supplies which are considered by the Trustees to be medically necessary considering the patient's condition and Diagnosis. For example, (by way of illustration and not limitation) non-emergency Hospital admission and confinement over a weekend will be presumed not medically necessary and not an eligible Expense Incurred. Hospital admission for surgery which is generally performed on an outpatient basis will not be considered eligible for benefits unless such admission is medically necessary due, for example, to a coexisting medical condition.

However, since this Plan offers maternity and newborn coverage, you are advised that under federal law, this Plan may not restrict benefits (or fail to provide reimbursement) for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. Also, by law, the Plan may not require authorization from the Plan administrator for prescribing a length of stay not in excess of the above periods. However, federal law does not prohibit a mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Work-Related Disabilities

Payment will not be made by the Plan for expenses incurred because of disease, defect or accidental injury, which occurs during or arises out of, any occupation for wage or profit (including side jobs). If the Eligible Person's claim under Workers' Compensation or any

Occupational Disease Law is rejected, the illness or injury may not be considered work related and payment may be made. However, the Trustees reserve the right to determine, in their sole discretion, if a claim is work related.

A claim under Workers' Compensation or under any Occupational Disease Law will be considered to have been rejected under the following circumstances:

1. When, after a hearing by the Illinois Workers' Compensation Commission (or the corresponding agency in another state), there has been a final administrative determination that the claim is not work related and the time limit for filing a court review of the decision has been exceeded; or

2. After a decision has been rendered by the Illinois Workers' Compensation Commission (or corresponding agency in another state) that the claim is not work related, a party has sought court review of the decision and a final court determination has been made affirming that the claim is not work related.

Self-Inflicted Injury or Substance Abuse

Payment will not be made for self-inflicted injury such as attempted suicide (whether sane or insane) or substance abuse to the extent such exclusion is permitted by law.

Treatment Sponsored by Governmental Units

Payment **will not** be made by the Plan for expenses incurred:

1. While confined in a Hospital owned or operated by the federal government or any other government unit; or

2. For treatment by a Physician employed by the Federal Government or any other governmental unit; or

3. For services or supplies furnished by or at the request or direction of, the Federal Government, any of its agencies or any other government unit unless the Eligible Person is legally required to pay for such supplies or services.

This exclusion will not prevent the coordination of benefits with a plan specifically established by a governmental unit for its own civilian Employees and their dependents. In addition, if Federal Law prohibits this Plan from being secondary to any Veteran's Administration benefits then, this exclusion will not apply to the extent that Federal Law prohibits that coordination of benefits.

Treatment without Charge

Payment will not be made for charges by any service provider when the service provider makes no charge that the Eligible Person is legally required to pay. In addition, payment will not be made for charges by any service provider when, in the absence of these benefits, the service provider would make no charge to the Eligible Person.

Illegal Occupation or Commission of Felony

The Trustees will not pay any claims for any loss to which a contributing cause was the commission of or attempt to commit, a criminal act or acts initiated by the Eligible Person whose

injury or Sickness is the basis of the claim. In addition, the Trustees will not pay any claims for any loss to which a contributing cause was the engagement in or attempted engagement of, an illegal occupation by the Eligible Person whose injury or Sickness is the basis of the claim. Criminal acts shall include, but not be limited to, acts defined as criminal under any Federal or State law, penal code or motor vehicle code. Specifically, driving under the influence of alcohol or drugs shall be considered criminal for purposes of this definition (except if driving under the influence is due to a physical or mental health condition or as a result of domestic violence). Determinations of coverage shall not be dependent upon a conviction by the governmental authority. Injury or injuries sustained by an Eligible Person resulting from assault and/or battery committed by that Eligible Person shall also be excluded from coverage. The Trustees will determine, solely in their discretion, whether a crime has been committed for the purposes of this section.

Payment will not be made for confinement in any Hospital or treatment by any provider otherwise eligible under this Plan when such treatment is ordered as a part of any litigation, court-ordered judgment or penalty including, but not limited to, psychiatric evaluation or counseling and confinement, evaluation or other treatment related to alcoholism or substance abuse (to the extent permitted by applicable law).

Experimental or Investigational Treatment or Procedures

"Experimental or Investigational Treatment or Procedures" means treatment, procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness; and/or, (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to the Eligible Person; and, (3) specifically with regard to drugs, a combination of drugs and/or devices, which is not finally approved by the Federal Drug Administration at the time used by or administered to the Eligible Person.

Treatment (medicines, surgery, techniques, devices and procedures) which is not generally recognized by professional medical peer groups, such as the American Medical Association, may be considered experimental or investigational. Recognized treatment that is used in a non-routine manner, such as frequency or dosage, may be considered experimental or investigational. If a particular form of medical treatment has been subject to a multiple phase set of clinical trials, such as developing cancer treatment, completion and publication of the results of the last phase of the clinical trials must occur before a treatment may be considered to be non-experimental or non-investigational.

The Board of Trustees will use its sole discretion to determine if a particular procedure, drug, device, service and/or supplies are experimental or investigational based upon the Board's review of the substantial evidence presented. The Board reserves the right to consult independent experts from outside sources in an effort to aid it in reaching a determination.

Other Types of Liability Insurance for Accidental Injuries

Benefits under this Plan are considered secondary to and may be excess to, other insurance coverage, including but not limited to, automobile insurance, common carrier insurance or liability, general commercial liability, "umbrella" liability and real property insurance. No payment shall be made until proof is submitted to and accepted by, the Trustees that a proper claim has been made for any other applicable coverage. Plan benefits may be denied in full or coordinated with, any other applicable insurance coverage.

Other Plan Exclusions and Limitations

Benefits of this Plan do not cover any loss caused by, incurred for or resulting from:

1. Declared or undeclared war or any act thereof or as the result of military (however, if Federal Law prohibits this Plan from being secondary to any Veteran's Administration benefits then, this exclusion will not apply to the extent that Federal Law prohibits that coordination of benefits);

2. Services, treatment or supplies received from a dental or medical department maintained by a mutual benefit association of this or any other Employee benefit plan or labor Union;

3. Services, treatment or supplies, which are payable or furnished under any policy of insurance or other medical benefit plan or service plan for which the Trustees shall, directly or indirectly, have paid for all or a portion of the cost;

4. Services or treatment rendered or supplies furnished primarily for cosmetic purposes;

    a. Note: This exclusion does not apply to coverage mandated by the Women's Health and Cancer Rights Act. Under that Act if a mastectomy is performed, the Plan will cover reconstructive surgery, including surgery to produce a symmetrical appearance, a prostheses and treatment for lymphedema.

5. Expenses incurred for services performed or supplies furnished by other than a Physician;

6. Services, treatment or supplies rendered or furnished:

    a. Before the individual concerned became an Eligible Person; or

    b. Without the recommendation and approval of a legally qualified Physician;

7. Ambulance service or transportation between cities or states in excess of 100 miles (such as by ambulance, air ambulance, railroad or bus) unless judged by the Trustees as essential for treatment of a life-threatening illness or injury;

8. Expenses incurred for services performed and supplies that do not meet accepted standards of medical and dental practice;

9. Expenses incurred for the purpose of reversing tubal ligations, vasectomies or other sterilization procedures;

10. Special home construction to accommodate a disabled person;

11. Rest cures or Custodial Care;

12. Speech therapy, other than charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words and form sentences) while eligible in the Plan and as the result of a disease or accidental injury. Speech therapy to improve speech in the absence of disease or accidental injury (such as for a learning disability or speech delay) is considered special education and is not covered;

13. Supplies or equipment for personal hygiene, comfort or convenience;

14. Services, treatment or care rendered by a member of the Eligible Person's family;

15. Treatment or services for or in connection with financial counseling;

16. Cosmetic or reconstructive surgery

Note: This exclusion does not apply to coverage mandated by the Women's Health and Cancer Rights Act. Under that Act if a mastectomy is performed, the Plan will cover reconstructive surgery, including surgery to produce a symmetrical appearance, a prostheses and treatment for lymphedema;

17. Dietary or nutritional counseling, books, pamphlets or classes (not including weight loss programs);

18. Charges incurred for any abortion procedure performed on an Eligible Dependent child except where the Pregnancy is the result of rape as evidenced by a police report;

19. Charges incurred for travel, whether or not recommended by a Physician;

20. Artificial insemination, in-vitro fertilization or embryo transfer process;

21. Naprapathic services;

22. Services related to gender reassignment;

23. Over-the-counter drugs unless prescribed by a Physician;

24. Hair growth treatments;

25. Cosmetic drugs, except for Retin-A;

26. Tooth transplants;

27. Dental services solely for cosmetic reasons;

28. Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical emergency;
29. Retreatment of root canal therapy within 24 months of initial treatment is not a covered benefit; and,

30. Accidental injuries for which a third party may be liable.

No benefits will be paid to an Eligible Person for expenses incurred due to an accidental injury for which a third party may be liable unless you and/or your Eligible Dependent sign a Subrogation/reimbursement agreement on a form approved by the Trustees. Under the terms of the subrogation/reimbursement agreement you and/or your Eligible Dependent, must agree that if you recover any amount from a third party relating to your accidental injury, you will repay the Fund the benefits which had been paid, without deduction for any expenses or attorney's fees.

Under the provisions of the subrogation/reimbursement agreement, if you and/or your Eligible Dependent do not pursue or prosecute a claim against the third party to recover for your injuries, then you and/or your Eligible Dependent must agree to authorize the Fund to bring a claim, at its option, in your name and/or in the name of you and/or your Eligible Dependent

against the third party, including the authority to file a lawsuit in court. You and/or your Eligible Dependent must agree to cooperate fully with the Fund in any action, which the Fund may take. After a loss for which the Fund has paid benefits, neither you nor your Eligible Dependent must do anything which impairs the Fund's right to recover the benefits paid on your behalf.

If you and/or your Eligible Dependent accept any settlement or receive any award for future medical expenses related to any injury or illness that had been caused by a third party, any such future medical expenses are not eligible expenses under this Plan.

For more details on this exclusion please refer to the section below entitled "Subrogation and Reimbursement."

Subrogation and Reimbursement

The purpose, of the Plan is to pay covered expenses if they are not paid or payable by anyone else, whether or not such payments are the legal responsibility of the eligible Employee or another eligible individual. It is the intent of the Trustees that no person shall receive any profit from the payment of insurance or other benefits or from the payment of any compensation for injuries.

In some cases, a third party is or may be responsible or liable for paying all or part of the expenses for which a claim is filed with the Plan; such a situation is called a "*third party incident."* A *third party* is any person or entity other than the person receiving the services. A third party could be, but is not limited to: a third party tortfeasor (an individual or other entity of any kind who caused harm, such as the driver of another car in an automobile Accident); an Employee welfare plan or arrangement; a medical or Hospital benefit plan; a no-fault or other car insurance policy; an uninsured or underinsured motorist provision or medical pay provision of your car insurance policy; a homeowners' insurance policy; a liability insurance policy of any kind or nature.

"Subrogation" is a legal term for a rule that gives the Plan the right to be repaid for benefits it pays on a claim if a third party is responsible for paying the expenses for which the claim is made.

"Compensation" includes any judgment, award or any settlement, whether or not the terms of the judgment, award or settlement specifically includes or excludes medical expenses and disability recovery.

If a claim is submitted for expenses for which a third party is or may be legally responsible:

1. The eligible Employee (and any adult eligible individual for whom reimbursement of covered expenses is claimed under the Plan), must agree to and execute a "*repayment and subrogation agreement"* in a form acceptable to the Trustees or legal counsel for the Trustees before benefits will be payable under the Plan; and
2. Such eligible Employee or other adult eligible individual must agree: (a) that the Plan will have a lien on the proceeds of any recovery arising out of the third party incident to the full extent of its subrogation rights and to the full extent of its rights to repayment under the repayment and subrogation agreement that may be independent of its subrogation rights; (b) that, to the full extent of benefits paid pursuant to the Plan, such recovery will be held in trust for the sole use and benefit of the Plan and that the Plan shall have the right to obtain payment of such recovery being thus held in trust; and (c) that the Plan may sue in any court of competent jurisdiction to enjoin the use of such proceeds for any purpose other than their payment to the Plan; and

3. The attorneys for all such persons must sign an agreement that they will honor and enforce the terms of the repayment and subrogation agreements before disbursing the proceeds of any recovery arising out of the third party incident; and
4. If the injured individual is a minor or is otherwise legally incompetent, the eligible Employee and the legally incompetent person's parent, legal guardian or “next friend” must sign a legally binding repayment and subrogation agreement on behalf of the injured incompetent person as a condition precedent to the Plan's obligation to pay any benefits arising out the third party incident.

The repayment and subrogation agreement specifies, among other things, that the eligible Employee and the injured individual agree:

1. That the eligible Employee and/or the injured individual will repay to the Plan the amount of such assets held in trust for the Plan, whether or not the claimant is made whole by any subsequent recovery; and
2. That the Trustees may participate in any legal action filed against a third party by or on behalf of the eligible Employee and/or the injured individual to recover the expenses; and
3. That the Trustees may file suit in the name of the eligible Employee and/or the injured individual to recover the expenses the Plan pays on the claim if the responsible party does not pay for the expenses voluntarily and if the eligible Employee and/or the injured individual does not sue the responsible party for recovery of the expenses; and
4. The eligible Employee and/or the injured individual will notify the Trustees before, accepting any payment prior to the initiation of a lawsuit. If the Plan is not notified and less than the full amount of the benefits advanced by the Plan have been accepted, the eligible Employee and/or individual will still be required to repay the Plan, in full, for any benefits paid. The Plan may withhold benefits if the eligible Employee and the injured individual waive any of the Plan’s rights to recover or fail to cooperate with the Plan in any respect regarding the Plan's reimbursement or subrogation rights. If the eligible Employee and eligible individual refuse to reimburse the Plan from any recovery or refuse to cooperate with the Plan regarding its subrogation or reimbursement rights, the Plan has the right to recover the full amount of all benefits paid by methods which include, but are not necessarily limited to, offsetting the amounts paid against future benefit payments under the Plan. Non-cooperation includes the failure of any party to execute a repayment and subrogation agreement and the failure of any party to respond to the Plan’s inquiry concerning the status of any claim, request for any information or any other inquiry relating to the Plan’s rights.

The Plan shall not be liable for, nor shall it have any obligation to pay, any benefit arising out of a third party incident unless and until a repayment and subrogation agreement in a form satisfactory to the Trustees executed by all persons to the full satisfaction of the Trustees, has been received by the Plan.

No individual will be required to repay to the Plan more than the benefits the Plan pays on the claim, nor more than the gross amount the injured individual receives in recovery, whichever is less, without regard to attorneys’ fees and expenses incurred in obtaining any such recovery; however, the Plan may agree to share in the payment of the injured individual’s attorney’s fees if the Trustees determine it is in the Plan's interest to do so.

The repayment and subrogation agreement, the Plan's right of Subrogation and the Plan’s right to recover assets held in trust for its benefit are separate and distinct rights and obligations and the failure or invalidity, in whole or in part, of one such right or obligation shall not impair or otherwise adversely affect any other such right or obligation.

If a judgment or settlement is received by or on behalf of the injured individual, the individual on whose behalf the Plan paid benefits shall repay to the Plan the lesser of the full amount of benefits the Plan paid or the amount of any recovery, whether or not that individual was legally responsible for the payment of those expenses. If such repayment is not made to the Plan the Plan shall have the right, in addition to any other legal rights it may have, to reduce future benefits on claims made by the eligible Employee and any Eligible Dependent, until the full amount of the agreed upon repayment has been paid to the Plan.

Notwithstanding the foregoing, no benefits will be paid under the Plan if the law or public policy of the state in which the person lives or in which the claim against the third person has been or may be filed, prohibits the Plan from being reimbursed in the event the person, whether or not a minor, recovers from the third person, unless such prohibition is unenforceable because it is preempted by the Employee Retirement Income Security Act of 1974, as amended.

Payment of Benefits for Compensated Injuries

For the purposes of this provision, *"compensated incident"* shall mean any occurrence taking place at any time or over a period of time from which any settlement, award or recovery is or was granted to an eligible individual. It includes a single act or a number of acts occurring over a period of time which result in injury to the eligible individual (such as, but not limited to, continued exposure to a harmful agent, prolonged misdiagnosis of a condition, etc.).

Notwithstanding any provision of the Plan to the contrary, no benefit shall be payable under the Plan for any covered expense which arises out of or is attributable to a compensated incident, either directly or indirectly, unless and until the total of benefits payable under the Plan's terms for all claims related to that incident equals or exceeds the total amount of compensation paid from another source. In determining the total amount paid by another source, the Plan will include amounts paid for medical services provided or rendered as a result of or in connection with any injury, Sickness, Accident or condition arising out of or related to the compensated incident, whether the compensation is in the form of a judgment, settlement or otherwise and however such compensation is described or designated.

This, provision shall apply irrespective of the designation or description of such compensation or recovery (i.e., loss, punitive damages. pain and suffering, medical expenses, attorneys' fees costs, etc.). For the purpose of this provision, any and all compensation and recovery shall first be applied to compensation for medical expenses.

This provision shall apply regardless of who institutes the action against another source and regardless of who pays the compensation or recovery to the eligible individual and whether recovery is in the form of a judgment, settlement or otherwise and whether the eligible Individual is an eligible Employee or an Eligible Dependent or a legally competent or incompetent person or a representative of any such person.

The determination of whether a covered expense is within the purview of treatment and/or service attributable to a compensated incident is a question of fact which shall be determined by the Trustees in their sole discretion.

The eligible individual (or, in the case of an incompetent eligible individual, his or her representative), shall assist and cooperate with representatives designated by the Trustees in making a determination as to whether the treatment and/or service can be attributable to the compensated incident. The eligible individual (or, in the case of an incompetent eligible individual, his or her representative) shall sign any and all necessary documents, releases and waivers reasonably requested by the Trustees or their representatives in making their

determinations of whether the treatment and/or service can be attributable to the compensated incident. No benefit shall be payable for any covered Expense Incurred in the treatment of a condition or injury which may be attributable to a compensated incident, whenever incurred, to or on behalf of an eligible individual during any period of time during which the eligible individual or, if applicable, the representative, fails or refuses to render reasonable aid or sign any document, waiver or release reasonably related to furthering the intent of this provision.

This provision shall in no way affect or otherwise diminish the Plan's right to subrogation or recovery under a repayment agreement for medical expenses incurred prior to or if applicable, subsequent to, the eligible individual's recovery.

This provision shall not be deemed waived by reason of satisfaction or release of the Plan's claim or lien under the Plan's subrogation rights without the express written agreement by the Trustees of such waiver. Any purported waiver of this provision by an eligible individual (or, in the case of an incompetent eligible individual, his or her representative) shall be null and void insofar as it applies to the Plan or Trustees or to any benefits claimed to be due and owing under the Plan.

CLAIMS PROCEDURE

UNLESS PROHIBITED BY LAW THE CLAIMS PROCEDURES IN THIS SECTION MUST BE USED BEFORE YOU CAN FILE A LAWSUIT RELATED TO THIS PLAN.

You as an Eligible Person may file a claim with any of the Fund's Claims Paying Agents for benefits. The claim must be in writing and must contain the following information:

1. A description of the claim;

2. The facts supporting the claim;

3. The amount claimed; and

4. The name and address of the person filing the claim.

Pre-Service Claims

If you fail to follow the pre-approval procedures for pre-service claims, you will be notified of the failure and of the proper procedures for filing these claims not later than 5 days (24 hours in the case of a failure to file a claim for urgent care) following the failure if your communication is received by the organizational unit that normally handles these claims and if the communication names a specific claimant, a specific medical condition and a specific product or treatment for which approval is requested. You may request written notification.

Timing of Benefit Determinations

The timing of benefit determinations for the following types of claims and decisions is as follows:

Urgent Care Claims

The Fund's Claims Paying Agent will designate a representative to answer urgent care claims as soon as possible (taking into account medical exigencies) but no later than 72 hours after receipt of the claim if sufficient information is provided so that a determination may be made as to the extent benefits are covered under the Plan. If you fail to provide sufficient information, you shall (1) be notified as soon as possible (and not later than 24 hours after the receipt of the claim by the Plan) of the specific information needed to complete the claim and (2) given a reasonable amount of time (and not less than 48 hours) to provide such information. For purposes of these claims procedures the term "urgent care claim" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations- (l) Could seriously jeopardize your life or health or your ability to regain maximum function or, (2) In the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The Fund's Claims Paying Agent will notify you of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

1. The Plan's receipt of the specified information or

2. The end of the period afforded you to provide the specified additional information.

If your claim is denied, you may request orally or in writing an expedited review of the claim. If such review occurs, all necessary information shall be transmitted by fax or telephone or another equivalent method.

Concurrent Care Decisions

If the Plan has approved an ongoing course of treatment over a specified time or for a specified number of treatments, any reduction or termination by the Plan of such course of treatment before the end of such period of time or number of treatments will constitute an adverse benefit determination. The Fund's Claims Paying Agent will notify you of the adverse benefit determination sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. For claims involving urgent care, if you request to extend the course of treatment beyond the period of time or number of treatments then your request will be decided as soon as possible, taking into account the medical exigencies. The Fund's Claims Paying Agent will notify you of the benefit determination within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Pre-Service Claims

The Fund's Claims Paying Agent will notify you of the Plan's benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Fund's Claims Paying Agent both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, you will be afforded at least 45 days from receipt of the notice within which to provide the specified information and the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Post-Service Claims

The Fund's Claims Paying Agent will notify you of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Fund's Claims Paying Agent both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, you shall be afforded at least 45 days from receipt of the notice within which to provide the specified information and the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Notification of Benefit Determinations

If the claim results in an adverse benefits decision, you will be provided with a written or electronic notice containing:

1. The specific reasons for the denial;

2. References to the specific provisions in the Plan document on which the denial is based;

3. A description of any additional information needed to perfect the claim and an explanation of why the additional information is needed; and

4. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a).

5. If applicable, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request;

6. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request;

7. In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims. For urgent care claims, the above information may be provided to you orally provided that a written or electronic notification containing this information is furnished to you not later than 3 days after the oral notification.

In the case of a claim for Short Term Disability filed on or after April 1, 2018, you will also be provided with an explanation for the Plan disagreeing or not following:

1. The views of the health care professionals treating you and the vocational experts evaluating you that you present to the Plan;

2. The views of medical or vocational experts whose advice was obtained by the Plan in conjunction with your claim, regardless of whether the Plan relied upon that advice; and

3. A disability determination presented by you to the Plan made by the Social Security Administration.

Appeals of Adverse Benefit Decisions

If you are not satisfied with the action taken on your claim, you have the right to appeal to the Board of Trustees through the Appeals Procedure as outlined in this section below. Remember, the Board of Trustees is the Plan Administrator even though another Claims Paying Agent may perform certain administrative duties. The procedures for appeals are set forth below in detail.

In reviewing your claim, every effort will be made by the Trustees to handle interpretations of the Plan and claims disputes in a consistent and equitable manner. The Trustees have full discretionary authority to determine eligibility for benefits under the Plan and to interpret the Plan, all Plan documents, Plan rules and procedures and the terms of the Trust Agreement. Their decisions and interpretations will be given the maximum deference permitted by law for the exercise of such full discretionary authority and will be binding upon all persons involved. In other words, to summarize: Benefits under this Plan will be paid only if the Board of Trustees decides in its discretion that the applicant is entitled to them.

Your Right to Request Review of an Adverse Benefit Determination

The Employee Retirement Income Security Act of 1974, as amended (ERISA) claims procedure regulations protect you by providing you the opportunity to request review of an adverse benefit determination.

An adverse benefit determination is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial based on your eligibility to participate in the Plan. You may request review of an adverse benefit determination on a pre-service claim, an urgent care claim or a post-service claim.

"Pre-service claim" means a claim for a benefit where the Plan conditions receipt of the benefit, in whole or in part, on obtaining approval in advance of receiving medical care.

"Urgent care claim" means a claim for medical care or treatment where applying the time periods for non-urgent determinations could seriously jeopardize your life or health or your ability to regain maximum function or in the opinion of a Physician who knows your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment you are seeking.

A claim will be found to be one involving urgent care in one of two ways. If a Physician with knowledge of your medical condition determines that the claim is one involving urgent care, we will treat it as such. Absent a determination by your Physician, we will determine whether a claim is one involving urgent care by using the judgment of a prudent layperson with average knowledge of health and medicine.

"Post-service claim" means all other claims that are not "pre-service claims" or "urgent care claims".

To obtain review of an adverse benefit determination, you must follow the review procedures below. These procedures vary, depending on whether you are asking for review of a decision on a pre-service, a post-service or an urgent care claim.

With the exception of requests for review of adverse benefit determinations involving urgent care claims, which may be made orally, all requests for review must be in writing. Normally, for all three types of claims, you must exhaust our internal review procedure before you can initiate a civil action under Section 502(a) of ERISA to obtain benefits.

Appeal Procedure

The appeal procedure which applies to your particular claim denial will vary depending upon the type of claim you filed which was denied. For appeal procedure purposes, a claim is classified as either: a Post-service claim, a Pre-service claim or an urgent care claim.

A. Appeal Procedure—Post-Service Claims

1. Under the appeal procedure for post-service claims, you are entitled to a two-level review process. The Fund's Claims Paying Agent which denied your claim—BCBSIL, Delta Dental of Illinois, The Sun Life Insurance Company (Sun Life) or Vision Service Plans (VSP) (hereafter "THE FUND'S CLAIMS PAYING AGENT")—must provide you with a written determination within 30 calendar days or receipt of your written requests for review at each level. However, that 30-day timeframe may be suspended if THE FUND'S CLAIMS PAYING AGENT has not received information they have requested in writing from you or from your health care provider, for example your Doctor or Hospital.

2. The appeal procedure for post-service claims provides two levels of review: To initiate review level 1 review, you or your authorized representative must send THE FUND'S CLAIMS PAYING AGENT a written statement explaining why you disagree with the determination. Please include in your request all documentation, records or comments you believe support your position. You must request review no later than 180 calendar days after you receive our decision on your claim for benefits. Mail your written request for review to the address found in the top right hand corner of the first page of your Explanation of Benefits statement or to the address contained in the letter THE FUND'S CLAIMS PAYING AGENT sends you to notify you that THE FUND'S CLAIMS PAYING AGENT has not approved a benefit or service you are requesting. THE FUND'S CLAIMS PAYING AGENT will respond to your request for review in writing within 30 days, unless they have notified you in writing that they need additional information to complete the review. If you agree with their response, it becomes their final determination and the review ends.

3. If you disagree with THE FUND'S CLAIMS PAYING AGENT response to your request for review at level 1, you may then proceed to level 2. You must request review at level 2 in writing no later than 30 calendar days after you receive THE FUND'S CLAIMS PAYING AGENT determination at level 1. Mail your request for a level 2 appeal to the Board of Trustees care of the Fund's Administrative Manager. Address your appeal to the Board of Trustees as follows:

Board of Trustees

IBEW Local No. 9 and Line Clearance Contractors Health & Welfare Fund c/o TIC International Corporation

6525 Centurion Drive

Lansing, Michigan 48917-9275

Again, please provide all documentation, records and comments, that you feel support your position. You will receive a written determination within 30 days of receipt of your request for review at level 2, unless you are notified in writing that additional information is needed to complete the review. The written determination at level 2 will be the final determination regarding your request for review.

4. If you disagree with the final determination or if the determination at each level is not issued within the 30-day time frame or the review procedures for level 1and level 2 are otherwise not complied with, you have the right to bring a civil action under Section 502(a) of ERISA to obtain your benefits.

B. Appeal Procedure—Pre-Service Claims

1. The appeal procedure for pre-service claims is identical to the review procedure for post-service claims, except that THE FUND'S CLAIMS PAYING AGENT must provide you with written determinations within shorter time frames. Appeals of pre-service claims also are handled in a two-step process. A determination will be issued within 15 calendar days of receipt of your request for a level 1 review and within 15 calendar days of your request for a level 2 appeal. You still have 30 days after receipt of the level 1 determination to file your level 2 appeal.

2. If you disagree with the final determination or if the determination at each level is not issued within the 15-day time frame or the review procedures for level 1and level 2 are otherwise not complied with, you have the right to bring a civil action under Section 502(a) of ERISA to obtain your benefits.

C. Appeal Procedure—Urgent Care Claims

The appeal procedure for urgent care claims is as follows:

1. You or your Physician may submit your request for an internal review orally or in writing. If you choose to submit your request for review orally, please call BCBSIL for urgent medical care claims at (800) 367-8309.

2. THE FUND'S CLAIMS PAYING AGENT must provide you with their decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review. All necessary information, including THE FUND'S CLAIMS PAYING AGENT decision on review, will be transmitted to you or to your authorized representative by telephone, facsimile or other available similarly expeditious method. If THE FUND'S CLAIMS PAYING AGENT decision is communicated orally, they must provide you or your authorized representative with written confirmation of their decision within 2 business days.

3. If you disagree with THE FUND'S CLAIMS PAYING AGENT final determination or if they fail to issue the determination within 72 hours or otherwise fail to comply with the review procedures, you have the option to bring a civil action under Section 502(a) of ERISA to obtain your benefits.

In addition to the information found above, the following requirements apply to the appeal of all types of claims (pre-service, post-service and urgent care claims).

a. You may authorize in writing another person, including, but not limited to, a Physician, to act on your behalf at any stage in the standard internal review procedure.

b. No fees or costs may be imposed as a condition to requesting review.

c. Although there are set timeframes within which you must receive the final determination on all three types of claims, you have the right to allow additional time if you wish.

d. You will be provided, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to your claims for benefits.

e. You may submit written comments, documents, records and other information relating to your claim for benefits and this information will be considered even if it was not submitted or considered in the initial benefit determination.

f. The person who reviews your adverse benefit determination will be someone other than the person who issued the initial adverse benefit determination. The determination on review will be a new determination; the initial determination on your claim will not be afforded deference on review.

g. If you request for review involves an adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment will be consulted.

h. Upon request, the medical experts whose advice was obtained in connection with the adverse benefit determination will be identified, even if their advice was not relied upon in making the determination.

i. On review, you will be advised of the specific reason for an adverse determination with reference to the specific Plan provisions on which the determination is based.

j. If an internal rule, guideline, protocol or other similar criterion is relied upon in making the adverse determination, you will be advised and provided a copy of the rule, guideline, protocol or other similar criterion free of charge upon request.

k. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, you will be advised and provided an explanation of the scientific or clinical judgment free of charge upon request.

l. If the Plan provides for any voluntary appeal procedures beyond the level 2 review, you will be advised of those procedures in the level 2 response.

There are special rules that apply to appeals of denials of claims for Short Term Disability filed on or after April 1, 2018.

Prior to the date, if the Plan denies an appeal of a claim for Short Term Disability, the Plan must provide you, free of charge, any new evidence or rationale considered or relied upon by the Plan and you will be given a reasonable opportunity to respond.

In the case of a denial of an appeal of a claim for Short Term Disability filed on or after April 1, 2018, you will also be provided with an explanation for the Plan disagreeing or not following:

1. The views you present to the Plan of the health care professionals treating you and the vocational experts evaluating you;

2. The views of medical or vocational experts whose advice was obtained by the Plan in conjunction with your claim regardless of whether the Plan relied upon that advice; and

3. A disability determination presented by you to the Plan made by the Social Security Administration

Expedited Review Process

For claims involving urgent care you may submit a request for an expedited review of an adverse benefit determination. If the Board of Trustees concurs with the request, your appeal may be submitted orally or in writing and all necessary information, including the Plan's benefit determination on review, shall be transmitted between you and the Plan by telephone, facsimile or other available similarly expeditious method.

The Board of Trustees has the discretion to determine eligibility for benefits and the amount of benefits payable, both initially and on review, make factual determinations and construe the terms of the Plan. Such determinations and constructions shall be conclusive and binding on all persons and entities.

Any decision rendered by the Board of Trustees, after compliance with the foregoing conditions and appeal procedures, shall be final and binding on all parties concerned.

Benefits under this Plan will be paid only if the Board of Trustees decides in its discretion that the applicant is entitled to them. This provision applies to all benefits payable under the Plan.

STATEMENT OF PARTICIPANT'S RIGHTS

Information Required by the Employee Retirement Income Security Act (ERISA)

Introduction

You have probably heard about ERISA. ERISA stands for the Employee Retirement Income Security Act, which was signed into law in 1974. This federal law establishes certain minimum standards for the operation of Employee benefits plans including the IBEW Local No. 9 and Line Clearance Contractors Health & Welfare Fund. The Trustees of your Fund, in consultation with their professional advisors, have reviewed these standards carefully and have taken the steps necessary to assure full compliance with ERISA. ERISA requires that Plan participants and beneficiaries be provided with certain information about their benefits, how they may qualify for benefits and the procedures to follow when filing a claim for benefits. This information has already been presented in the preceding pages of this Summary Plan Description.

ERISA also requires that participants and beneficiaries be furnished with certain information about the operation of the Plan and about their rights under the Plan. This information follows:

READ THIS SECTION CAREFULLY. Only by doing so can you be sure that you have the information you need to protect your rights and your best interests under this Plan.

Your Rights as a Participant

As a participant in the IBEW Local No. 9 and Line Clearance Contractors Health & Welfare Fund:

1. You will automatically receive a Summary Plan Description (this booklet). The purpose of this booklet is to describe all pertinent information about the Plan.

2. If any substantial changes are made in the Plan, you will be notified within the time limits required by ERISA.

3. Each year you will automatically receive a summary of the Plan's latest annual financial report. A copy of the full report is also available upon written request.

4. You may examine, without charge, all documents relating to this Plan. These documents include: the legal Summary Plan Description/Plan Document, collective bargaining agreements and copies of all documents filed by the Plan with the Department of Labor or the Internal Revenue Service, such as annual reports and Plan descriptions. Such documents may be examined at the Fund Office (or at other required locations such as work sites or Union halls) during normal business hours.

5. To assure that your request is handled promptly and that you have been given the information you want, the Trustees have adopted certain procedures which you should follow:

    a. Your request should be in writing;

    b. It should specify what materials you wish to look at; and

c. It should be received at the Fund Office at least three days before you want to review the materials at the Fund Office.

Although all pertinent Plan documents are on file at the Fund Office, arrangements can be made upon written request to make the documents you want available at any work site or Union location at which 50 or more participants report to work. Allow ten days for delivery.

6. You may obtain copies of any Plan document upon written request to the Trustees, addressed to the Fund Office. ERISA provides that the Trustees may make a reasonable charge for the actual cost of reproducing any documents you request.

7. You are entitled to know, however, what the charge will be in advance. Just ask the Fund Office.

8. No one may take any action, which would prevent you from obtaining a benefit to which you may be entitled or from exercising any of your rights under ERISA.

9. In accordance with Section 503 of ERISA and related regulations, the Trustee have adopted certain procedures to protect your rights if you are not satisfied with the action taken on your claim.

10. These procedures appear in the Appeal section of this booklet. Basically they provide that:

    a. If your claim for a welfare benefit is denied in whole or in part, you will receive a written explanation of the reason(s) for the denial.

    b. Then, if you are still not satisfied with the action on your claim, you have the right to have the Plan review and reconsider your claim in accordance with the Plan's claims review procedures.

    c. These procedures are designed to give you a full and fair review and to provide maximum opportunity for all of the pertinent facts to be presented on your behalf.

11. In addition to creating rights for Plan participants, ERISA also defines the obligations of those people involved in operating Employee benefit plans.

These persons are known as "fiduciaries." They have the duty to operate your Plan with reasonable care and with your best interests in mind as a participant under the Plan.

Be assured that the Trustees of this Plan will do their best to know what is required of them as "fiduciaries" and to take whatever actions are necessary to assure full compliance with all state and federal laws applicable to the Plan.

12. Under ERISA, you may take certain actions to enforce the rights listed above.

    a. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Trustees.

Of course, before taking such action, you will no doubt want to check again with the Fund Office to make sure that:

i. The request was actually received and

ii. The material was mailed to the right address or

iii. The failure to send the material was not due to circumstances beyond the Trustees' control.

If you are still not able to get the information you want, you may wish to take legal action. The Court may require the Trustees to provide the materials promptly or pay you a fine until you actually receive the materials (unless the delay was caused by reasons beyond the Trustees' control).

b. Although the Trustees will make every effort to settle any disputed claims with participants fairly and promptly, in accordance with the Fund's rules, there is always the possibility that differences cannot be resolved to everyone's satisfaction.

For this reason, you may file suit in a state or federal court if you feel that you have been improperly denied a benefit. Any lawsuit must be filed in the U.S. District Court for the Northern District of Illinois, Eastern Division, and must be filed not later than two years after a final decision has been reached by the Trustees.

Before exercising the right to file suit, however, you must exhaust all the claim review procedures available under your Plan and then proceed only upon the advice of your attorney.

c. If you believe that Plan fiduciaries have misused the Plan’s money or have discriminated against you for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees.

We hope this Summary Plan Description has provided you with most important information about your Plan and your rights under ERISA.

If you have any questions about your Plan, you should contact the Trustees by writing to: IBEW Local No. 9 and Line Clearance Contractors Health & Welfare Fund, 6525 Centurion Drive, Lansing, Michigan, 48917-9275 or by calling the Fund Office: (517) 321-7502 or toll-free (877) 423-9155.

If you have any questions about this Statement or about your rights under ERISA which have not been answered in this Summary Plan Description or by the Fund Office, you should contact the nearest Area Office of the U.S. Department of Labor. The Fund Office will be glad to furnish the address.

Nothing in this statement is meant to interpret or extend or change in any way the provisions expressed in the Plan. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. Participants will be notified of any Plan changes pursuant to all legal requirements.

HIPAA PRIVACY INFORMATION

The Fund is subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Plan may disclose protected health information as defined by HIPAA to the Board of Trustees (which is the Plan sponsor) since the Board of Trustees has certified that the Plan documents have been amended to incorporate provisions of HIPAA.

The Trustees have previously provided a Privacy Notice to participants and will send an updated Privacy Notice when required by HIPAA. The Privacy Notice explains how protected health information can be used as disclosed by the Administrative Manager.

NONDISCRIMINATION IN HEALTH CARE

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. In this context, discrimination means treating a provider differently based solely on the type of the provider's license or certification. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

DEFINITIONS

Accident

An Accident must contain some degree of unexpected violence, such as a fall, blow, laceration, contusion or abrasion.

Accidental Bodily Injury

Accidental Bodily Injury means an injury or Sickness, which is the result of an Accident.

However, Accidental Bodily Injury does not include an accidental bodily injury or Sickness that arises out of or in the course of, employment. This exclusion from the definition shall not apply to the Life Insurance and Accidental Death & Dismemberment benefit.

Allowable Charge

The Allowable Charge is determined by uniform reference standards as adopted by the Board of Trustees. To be considered an Allowable Charge, the charge by any provider for a service must be similar to the charges generally incurred for cases of comparable nature and severity by a Physician of similar training and experience in that geographical area. Area means a metropolitan area, county or such greater area as is necessary to obtain a representative cross-section of providers rendering such service or furnishing such supplies.

With respect to Medical Equipment, a charge will be considered "allowable" only if the following requirements are met:

1. The expense of the equipment must be clearly proportionate to the therapeutic benefits ordinarily derived from its use; and

2. The equipment may not be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and

3. The equipment may not serve essentially the same purpose as equipment already available to the patient.

Ambulatory Surgical Center

An Ambulatory Surgical Center is a freestanding facility, which is wholly owned and operated by a Hospital on the same basis as the Outpatient department of its main facility or, a separate legal entity, which meets all of the following requirements:

1. It is established, equipped and operated primarily for the purpose of performing Surgical Procedures.

2. It operates under the supervision of one or more Physicians as defined by the Plan.

3. It is equipped with at least two operating rooms, at least one post-anesthesia recovery room and has the ability to perform diagnostic X-ray and laboratory procedures as required in conjunction with the surgery to be performed.

4. It continually provides nursing services by registered nurses for patient care in the operating rooms and the post-anesthesia recovery room(s).

5. It is licensed by the appropriate state agency and is recognized by the local medical society.

Covered Employment

Covered Employment means work performed for a Contributing Employer or Employers within the jurisdiction contained in the Collective Bargaining Agreement and for which the Employer is obligated to make, and has made, contributions to the Fund.

Custodial Care

Custodial Care means care, services or supplies, which are furnished mainly to train or to assist in personal hygiene or other activities of daily living, rather than to provide therapeutic treatment. Care, services or supplies will also be considered "custodial" if they can be safely and adequately provided by persons who do not have the technical skills of a covered health care provider.

Dental Hygienist

Dental Hygienist means a person who is currently licensed (if licensing is required in the State) to practice dental hygiene by the governmental authority having jurisdiction over the licensing and practice of dental hygiene and who works under the supervision of a Dentist.

Dentist

Dentist means a person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry.

Diagnosis

Diagnosis refers to the statement of the medical condition requiring the care of a Physician.

Educational Institution

Educational Institution means a trade school, college or university or other organization whose primary purpose is training and which regularly charges tuition for such training.

Educational Institution does not include "work-study" or other training programs during which the trainee receives compensation.

Elective or Voluntary Sterilization

Elective Sterilization is sterilization not medically required but requested by the patient and will include among others, vas ligation, vasectomy, salpingectomy and tubal ligation.

Eligibility Rules

The Eligibility Rules are defined in the section entitled Eligibility Rules and such rules shall apply to all Employees and their Dependents and to all Self-Pay Employees and their Dependents.

Eligible Dependent or Dependent

Eligible Dependents are the following:

1. The legal spouse of the eligible Employee;

2. Any child until the last day of the month, in which the child reaches age 26. This includes the eligible Employee's natural children, children legally adopted or placed with you for adoption, stepchildren and foster children. However, any child 18 or over who is eligible to enroll in another health plan sponsored by either their Employer or their spouse's Employer shall not be eligible for coverage under this Plan prior to January 1, 2019;

3. Any unmarried disabled child over age 26 provided the disability was sustained prior to age 26 and the child is chiefly Dependent upon you for support.

The term Eligible Dependent does not include a grandchild; that is, a child of a Dependent child.

In the event that an Employee has a child during his or her eligibility, the natural child of the Employee is covered as an Eligible Dependent. However, the mother, if she is not the Employee, must still meet the eligibility requirements in order to be considered an Eligible. That is, the mother of an Employee's child is not automatically an Eligible Dependent, even if the child is. The mother must also meet the Plan's eligibility requirements to be considered an Eligible Dependent.

In the event that the legal spouse of the Employee has a child that is not the natural child of the Employee, the eligibility of the child is conditioned upon independently satisfying the Eligible Dependent eligibility requirements.

Eligible Person

An Eligible Person means either the eligible Employee or the eligible Employee's Eligible Dependents.

Employee

An Employee means a person, actively employed by an Employer and working under Covered Employment, on whose behalf Employer contributions are required to be made.

Employer

Employer or Contributing Employer means any association or individual Employer who has duly executed a collective bargaining agreement with the Union and is thereby required to make contributions to this Fund on behalf of its Employees. Any Employer not presently party to such collective bargaining agreement who satisfies the requirements for participation as established by the Trustees and agrees to be bound by the Trust Agreement is also included within this definition.

Expense Incurred

Expense Incurred includes only those charges made for services and supplies, which are reasonably priced and medically necessary for treatment of the injury or Sickness.

Health Insurance Portability and Accountability Act

A Law which limits the circumstances under which coverage may be excluded for medical conditions before your enroll. This Plan does not have a pre-existing condition exclusion.

Hospital

A Hospital is any legally constituted institution, which meets all the following requirements:

1. Maintains permanent and full time facilities for bed care of five (5) or more resident patients; and

2. Has a Doctor in regular attendance; and

3. Continually provides a twenty-four (24) hour-a-day nursing service by registered nurses; and

4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for drug addicts or a place for alcoholics; and

5. Is operating lawfully in the jurisdiction where it is located.

Inpatient

Inpatient means a person who is a resident patient using and being charged for the room and board facilities of the Hospital.

Intensive Care Unit

Intensive Care Unit means a special area of a Hospital, exclusively reserved for critically ill patients requiring constant observation, which in its normal course of operation provides:

1. Personal care by specialized registered professional nurses and other nursing care on a 24-hour per day basis;

2. Special equipment and supplies which are immediately available on a stand-by basis; and

3. Care required, but not rendered, in the general surgical or medical nursing units of the Hospital. The term "Intensive Care Unit" shall also include an area of the Hospital designated and operated exclusively as a Coronary Care Unit or as a Cardiac Care Unit.

Medical Equipment

Medical Equipment means equipment which meets all of the following requirements:

1. Is primarily and customarily used to serve a medical purpose; and

2. Is generally not useful to a person in the absence of illness or injury; and

3. Is necessary and reasonable for the treatment of an illness or injury, which is covered by the terms of this Plan.

To be considered "Medical Equipment," a device must make a meaningful contribution to the treatment of a patient's illness or injury or to the improved functioning of a malformed or damaged body member. Equipment, which primarily serves a comfort or convenience function for the patient or the patient's caretaker (such as a wheelchair ramp or a vehicle lift device), is not considered "Medical Equipment."

Medicare

Medicare means the program established by Title XVIII of the Social Security Act. Medicare Secondary Payer or MSP

Medicare Secondary Payer or MSP means those provisions of the Social Security Act and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain Employers may offer group health care coverage to Medicare-eligible Employees, their spouses and, in some cases, Dependent children.

Optician, Optometrist and Ophthalmologist

Optician, Optometrist and Ophthalmologist means any person who is qualified and currently licensed (if licensing is required in the State) to practice each such profession by the appropriate government agency or authority having jurisdiction over the licensing and practice of such a profession and who is acting within the usual scope of his practice.

Outpatient

Outpatient means a person who receives Hospital services and treatments, but is not an Inpatient.

Period of Disability Confinement

Successive periods of disability or Hospital confinement are considered one continuous disability and period of confinement for the purpose of determining maximum benefits payable unless:

1. The later treatment period is due to causes entirely unrelated to the causes of the prior treatment; or

2. The periods of treatment are separated by ninety (90) calendar days; or

3. For an Employee, a return to Covered Employment for at least two (2) weeks.

Physician, Doctor or Surgeon

Physician, Doctor or Surgeon includes Osteopaths, Dentists and Podiatrists or Chiropodists when practicing within the scope of their respective licenses.

A Chiropractor is not considered to be a Physician for most benefits under this Plan. A Naprapath is not considered to be a Physician for benefits under this Plan.

Pregnancy

Pregnancy includes resulting childbirth, miscarriage and any complications of Pregnancy. Pregnancy shall be treated as any other Sickness.

Routine Physical Examination

A Routine Physical Examination is an examination done by a Physician for screening purposes. If there is no Diagnosis or symptoms presented on a claim form or itemized bill by the Physician, the care will be considered routine.

Sickness

Sickness means a deviation from a healthy condition which:

1. Alters the state of the body; and

2. Interrupts or disturbs the performance of vital functions; and

3. Tends to undermine or weaken the constitution.

Sickness does not include a limitation on or a loss of body function or a temporary indisposition, which does not progressively undermine or weaken the constitution. Sickness caused or contributed by self-abuse, such as alcoholism or intentional overdose of drugs, are generally subject to special limitations and may be excluded from coverage entirely.

Skilled Nursing Care Facility

Skilled nursing care facility means an institution or that part of any institution, which operates to provide convalescent or nursing care and:

1. Is primarily engaged in providing to Inpatients:

    a. Skilled nursing care and related services for patients who require medical or nursing care; or

    b. Rehabilitation services for the rehabilitation of injured, disabled or sick persons; and

2. Has a requirement that the health care of every patient be under the supervision of a Physician; and

3. Has a Physician available to furnish necessary medical care in case of emergency; and

4. Has policies, which are developed with the advice (and with provision for review of such policies from time to time) by a group of professional personnel, including one (1) or more Physicians and one (1) or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides; and

5. Has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies; and

6. Maintains clinical records on all patients; and

7. Provides twenty-four hour nursing services which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph 2 and has at least one (1) registered professional nurse employed full time; and

8. Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals; and

9. In the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature:

    a. Is licensed pursuant to such law; or

    b. Is approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and

10. Meets any other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof.

Surgical Procedure

Surgical procedure means certain invasive procedures, as well as reduction of fractures or dislocations, in addition to recognized cutting procedures.

Total Disability

Total Disability, unless otherwise specifically defined, refers to a disability resulting solely from a Sickness or bodily injury which prevents an Employee from engaging in any occupation or employment for compensation or profit or which prevents an Eligible Dependent from engaging in substantially all of the normal activities of a person of like age and sex in good health. The Board of Trustees shall determine if an individual is totally disabled in its sole discretion. The person must also be eligible for Social Security disability benefits. A copy of the Social Security Administration Award Letter is required for proof of Total Disability.

Trust Agreement

Trust Agreement means the Agreement and Declaration of Trust establishing the Line Clearance Benefit Fund and that instrument as it may be amended from time to time.

Trust Fund

Trust Fund or Fund means the IBEW Local No. 9 and Line Clearance Contractors Health & Welfare Fund.

Trustees

Trustee means the Employer Trustees and the Union Trustees, collectively, as selected under the Trust Agreement and as constituted from time to time in accordance with the provisions of the Trust Agreement.

Union

Union means those Unions, which have executed a Collective Bargaining Agreement (CBA) with an Employer who, in accordance with such CBA, participates in and contributes to the IBEW Local No. 9 and Line Clearance Contractors Health & Welfare Fund.

IMPORTANT PLAN INFORMATION

The Trustees Interpret the Plan

Under the terms of the Trust Agreement that created the Fund and under the terms of this Plan, the Board of Trustees has the sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan and any administrative rules adopted by the Trustees. The Trustees have full discretionary authority to interpret and construe the Plan, all Plan Documents, the Trust Agreement, this Summary Plan Description and all Plan rules and procedures. The Trustees interpretation will be given the maximum deference permitted by law for the exercise of such full discretionary authority. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties to the Plan and the Welfare Plan provides that, such decision is to be upheld unless it is determined to be arbitrary or capricious. In other words, to summarize: Benefits under this plan will be paid only if the Board of Trustees decides in its discretion that the applicant is entitled to them.

Any interpretation of the Plan's provisions rests with the Board of Trustees. No Employer, Union, representative of any Employer, representative of any Union or any other individual or entity is authorized to interpret this Plan on behalf of the Board of Trustees. No Employer, Union, representative of any Employer, representative of any Union or any other individual or entity can act as agent of the Board of Trustees unless given actual authority by the Board of Trustees.

Although, the Board of Trustees has authorized the Administrative Manager and the Fund Office staff to handle routine requests from Eligible Persons regarding Eligibility Rules, benefits and claims procedures, if there are any questions involving interpretation of any Plan provisions, the Administrative Manager will ask the Board of Trustees for a final determination.

The Plan Can Be Changed

The Trustees have the legal right to change the Plan, subject to any collective bargaining agreement that applies to it.

Although the Trustees hope to maintain the present level of benefits and to improve upon them if possible, a primary concern of the Trustees is to protect the financial soundness of the Plan at all times. To do so may require Plan changes from time to time.

Changes in the Plan may also be required in order to preserve the Fund's tax-exempt status under Internal Revenue Service rules and regulations. These rules and regulations may change and as a result, the Trustees may find it necessary to change Plan provisions so that the Trust does not lose its tax-exempt status.

Your Plan is Tax-Exempt

Your Welfare Plan is classified by the Internal Revenue Service as a 501(c)(9) Trust Fund. This means that the Employer’s contributions to the Trust are tax-deductible and are not included as part of your income. Also, in most cases, the benefits paid on your behalf are not taxable as personal income. Also, investment earnings on Plan assets are excluded as taxable income of

the Trust since they are specifically set aside for the purpose of providing benefits to participants.

Obviously, such tax exemption works to the benefit of both Employer and Employee. In effect, it means that money which otherwise might be payable as taxes can be used to purchase benefits and to cover administrative expenses.

The Trustees are well aware of these advantages and will take whatever steps are necessary to keep your Plan "Qualified" and to maintain it as a tax-exempt Trust under Internal Revenue Code, ERISA and under the rules and regulations of the Internal Revenue Service and of the Department of Labor.

Right to Receive and Release Necessary Information

To determine the applicability of and to implement the terms of, this Plan or the similar terms of any other plan, the Fund may, without consent or notice to any covered person, release to or obtain from, any insurance company or other organization or individual, any information with respect to any covered person which the Fund deems to be necessary for such purposes. Any covered person claiming benefits under this Plan shall furnish to the Fund such information as may be necessary to implement this provision.

Right of Recovery

Whenever payments have been made by the Fund with respect to allowable charges in excess of the maximum amount of payment necessary at the time to satisfy its provisions, the Fund shall have the right to recover such payments, to the extent of such excess, from among one or more of the following as the Fund shall determine:

1. Any individual to whom or from whom, such payments were made; or

2. Any insurance company, Hospital, Physician or any other organization.

The Fund may also recover such excess payments by reducing future benefit payments, if any, for Employee’s, Eligible Dependents or beneficiaries.

Payment of Claims

Indemnity for loss of life will be payable in accordance with the beneficiary designation form on file at the Fund Office and in accordance with the provisions with respect to such payments which are prescribed in the Sun Life Insurance Booklet. The Sun Life Insurance Booklet provides for a method of distribution if a beneficiary designation card is not on file or if those named on the card predecease the participant.

Name of the Plan

IBEW Local No. 9 and Line Clearance Contractors Health & Welfare Fund.

Type of Plan

This Plan provides health care benefits for expenses incurred due to Hospitalization, surgical treatment, medical treatment, vision treatment or dental treatment. This Plan also provides

benefits for Death (Life Insurance), Accidental Death & Dismemberment (AD&D) and Short-Term Disability (also known as Weekly Accident and Sickness or Weekly Loss-of-Time).

Type of Plan Administration

Every Plan has a Plan Sponsor. The Board of Trustees is your Plan's Sponsor. The address for the Board of Trustees is:

Board of Trustees,
IBEW Local No. 9 and Line Clearance
Contractors Health & Welfare Fund
c/o TIC International Corporation
6525 Centurion Drive
Lansing, MI 48917-9275
Phone: (517) 321-7502 or Toll Free: (877) 423-9155
Fax: (517) 321-7508

The Plan is administered and maintained by the Board of Trustees. The Trustees have selected a professional Employee benefits administrative firm as the Administrative Manager of the Plan. The Administrative Manager maintains the Fund Office and is responsible for carrying out the Trustees' policy decisions, record keeping and accounting. The Trustees have entered into contracts with other Claims Paying Agents to pay benefits subject to the Plan Document.

Name and Address of Administrative Manager

The Administrative Manager selected by the Trustees is:
James E. Schreiber, Administrative Manager
TIC International Corporation
6525 Centurion Drive
Lansing, MI 48917-9275
Phone: (517) 321-7502 or Toll Free: (877) 423-9155
Fax: (517) 321-7508

Name and Address of Investment Consultant

Ted L. Disabato
Managing Principal
Maketa Investment Group, Inc.
1 East Wacker Drive, Suite 1210
Chicago, IL 60661
Phone: (312) 474-0905
Fax: (312) 474-0904

Custodian

Union National Bank
101 East Chicago Street
Elgin, Illinois 60120
Phone: (847) 888-7500
Fax: (847) 888-2662

Name and Title of Each Trustee

The Trustees of this Fund are:

Management Trustees	Union Trustees
Richard Heller, Secretary	William W. Niesman, Chairman
Herbert Zinzer (Alternate)	John C. Burkard
	Robert Cook
	Craig Nolan
	Robert Spychalski
	John G. Dowling
	Eric Bergdolld (Alternate)

Parties to the Collective Bargaining Agreement

The Fund is established and maintained under the terms of a collective bargaining agreement. This agreement sets forth the conditions under which participating Employers are required to contribute to your Fund.

In addition, those Employers that execute a letter of assent to a collective bargaining agreement with the Local Union may become Contributing Employers. Upon written request to the Administrative Manager, participants and Beneficiaries may obtain information as to the address of a particular Employer and whether that Employer is required to pay contributions to this Plan.

Internal Revenue Service Employer and Plan Identification Numbers

The Employer Identification Number (EIN) issued to the Board of Trustees is 36-3332983 the Plan Number is 501.

Agent for Service of Legal Process

James E. Schreiber, Administrative Manager
TIC International Corporation
6525 Centurion Drive
Lansing, MI 48917-9275

Service of legal process may also be made upon any Plan Trustee.

Eligibility Requirements

The Plan's requirements with respect to eligibility for benefits are shown in the Eligibility Rules in the Eligibility Section of this Document. Circumstances which may cause you to lose eligibility are explained in the Eligibility Rules in the Eligibility Section of this Document.

Sources of Trust Fund Income

Sources of Trust Fund income include Employer contributions, Employee self-payment of contributions and investment earnings. All Employer contributions are paid to the Trust Fund subject to provisions in the applicable collective bargaining agreement or non-bargaining participation agreements between the Union and an Employer Association or those Employers who are not members of or represented by an Association but who execute an individual collective bargaining agreement with the Local Union.

The agreements specify the amount of contributions, due date of Employer contributions, type of work for which contributions are payable and the geographic area covered by the labor contract.

Method of Funding Benefits

Benefits payable under this Plan are self-funded and paid directly from the accumulated assets of the Trust Fund. Except for Life and Accidental Death & Dismemberment benefits for which the Trust Fund has purchased a group insurance policy insured by Sun Life.

Fiscal Year of the Plan

The financial records of this Plan are based on a fiscal year, which begins July 1 and ends June 30.

The Plan May be Amended or Terminated

The Trust Fund Documents gives the Trustees the authority to amend the Plan if they determine that such amendment is necessary or desirable to further the purposes of the Trust Fund. You will be provided with notice of amendments when necessary in conformity with all legal requirements. Although the Trustees do not foresee that the Plan will be terminated, the Trust Agreement provides that termination may occur when:

1. The Trustees determine that the Trust Fund assets are not adequate to carry out the purpose for which the Welfare Fund is intended; or

2. There is no longer a collective bargaining agreement or other written agreement in effect that requires Employer contributions to be made to the Trust Fund and negotiations for extension thereof have ceased.

The Trustees are obligated to use the Trust Assets for payment of expenses incurred up to the date of termination and expenses related to the termination as their first priority. Remaining assets, if any, must be disbursed pursuant to the applicable provisions of the Trust Agreement.

Upon written request, you may examine the agreement at the Administration Office or other specified locations. Or, you may request of a copy of the agreement, which will be provided for a reasonable charge.

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IBEW LOCAL NO. 9
FRINGE BENEFIT FUNDS

IBEW Local No. 9 and Line Clearance Contractors Health & Welfare Fund — Managed for the Trustees by:
IBEW Local No. 9 and Line Clearance Contractors 401(k) Retirement Plan — TIC INTERNATIONAL CORPORATION

RE: IBEW LOCAL NO. 9 AND LINE CLEARANCE CONTRACTORS HEALTH & WELFARE FUND
Department of Transportation (DOT) Physicals

Dear Participant:

Your Health Care Plan provides for 100% coverage for DOT physicals, based on the Blue Cross Blue Shield of Illinois (BCBSIL) approved amount, provided you are eligible for benefits on the date of your DOT physical. DOT physicals are covered under your Wellness Benefit; however, they are ***not*** subject to a deductible.

Your Plan covers DOT physicals when they are billed with procedure codes 99450, 99455 or 99456. These are the only procedure codes covered under this benefit.

Most health care plans do not cover DOT physicals; this is a benefit unique to *your* Plan. Because this is such a unique benefit, many Physicians may try to have you pay for your DOT physical at the time of service. Getting your DOT Physicals paid by BCBSIL should no longer be a problem if you follow these simple guidelines.

Present your BCBSIL ID card at your Physician's office and ask them to take a copy of the front and back of the card

Direct them to the toll free number on the back of the card (800-367-8309) for membership verification and ask them to call to confirm your benefits for DOT physicals

Ask that they bill the physical with any of the following ***covered*** procedure codes: 99450, 99455 or 99456

If necessary, take this letter with you to your DOT physical appointment and have them photo copy this letter for your file.

If you have any questions, please contact the Customer Service Department of the Fund Office toll free at (877) 423-9155.

Sincerely,

Board of Trustees

6525 Centurion Drive • Lansing, MI 48917-9275
(517) 321-7502 • (517) 321-7508 FAX
Toll Free (877) IBEW-155
www.ibew9lctt.org